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405.401: Eligible Recipients

(A) Medical Assistance Recipients. The Department pays for community health center services provided to Medical Assistance recipients (categories of assistance 00, 01, 02, 03, 05, 06, 07, and 08) subject to the restrictions and limitations described in this Chapter 405.000.

(B) General Relief Recipients.

(1) The Department pays for limited community health center services provided to General Relief recipients (category of assistance 04). The following services are reimbursable when provided to General Relief recipients in accordance with this Chapter 405.000:

(a) visits as described in Section 405.421 with the exception of hospital visits;
(b) laboratory services;
(c) vision care services;
(d) dental services; and
(e) pharmacy services.

(2) Services that are not reimbursable when provided to General Relief recipients include:

(a) podiatry services;

(b) physical, speech, and occupational therapy services;
(c) psychological testing;
(d) speech and hearing evaluations; and
(e) radiology services.

405.402: Provider Eligibility

Payment for the services described in these regulations will be made only to providers of community health center (CHC) services who are participating in the Medical Assistance Program on the date of service. In order to participate in the Medical Assistance Program, a CHC must meet the qualifications for certification, provisional certification, or special certification in Section 405.403.

405.403: Certification

(A) Application. An application for certification as a CHC shall be made on the form provided by the Department and shall be submitted to the Medical Division's Program Director for Community Health Centers. Upon receipt of the completed application, the Program Director or his designee may arrange a site visit with the applicant to determine compliance with Sections 405.404 through 405.413 inclusive, and if the applicant offers one or more of the services described in Sections 405.431 through 405.491, compliance with the applicable portions of those sections. Based on the information revealed by the application and the site visit, the Department will determine whether the applicant is certifiable, provisionally certifiable, specially certifiable, or not certifiable. The Program Director will promptly notify the applicant of the determination in writing. If the applicant is not certifiable, the notice shall contain a statement of the reasons for that determination.

(B) Certification. A determination of certifiability indicates that the applicant has been found by the Department to be in compliance with Sections 405.404 through 405.413 inclusive and, to the extent applicable, with Sections 405.431 through 405.491.

(C) Provisional Certification. Provisional certification means that the Department has determined the applicant to be in compliance with the sections referred to in Subsection (B) above except for one or more of the following: Subsection 405.406(F) (Nutrition Services), Subsection 405.406(C) (Obstetrics/Gynecology), Section 405.411 (Translation Services), or Section 405.412 (Medical/Emergency Backup Services). If an applicant has been provisionally certified,

the letter of notification shall specify the certification requirements with which the applicant has failed to comply and the schedule for achieving compliance. When requirements for full certification have been met, the Department will certify the CHC. A provisional certification is equivalent to certification, except that it will expire upon the date fixed in the letter of notification for full compliance, which date shall be not later than one year after the fixed date of the provisional certification.

(D) Special Certification. A hospital that provides special programs (for example, Title V Maternal and Infant Care Programs or Children and Youth Projects) at a CHC may apply for special certification to bill the Department for those programs in accordance with these regulations. The Department will review the application in accordance with the provisions of Subsection (A) above, except that the Department may, upon request of the applicant, waive such requirements of Sections 405.404 through 405.413 inclusive as the Department determines to be fulfilled by the CHC where such services are provided. If the applicant is specially certifiable, the Department will assign to the applicant a separate provider number to be used only for those services provided in accordance with these regulations.

(E) Review of Certification.

(1) The Medical Division's Program Director for Community Health Centers shall have the right to review a certified, provisionally certified, or specially certified provider's continued compliance with the conditions for certification referred to in Subsections (A), (B), (C), and (D) above upon reasonable notice and at any reasonable time during the hours of operation of the provider. The Program Director shall have the right to revoke the certification, provisional certification, or special certification of a provider, subject to any applicable provisions of 106 CMR 450.000, if such review reveals that the provider has failed to or ceased to meet such conditions.

(2) Any changes in the manager or professional-services director or in the scope of services provided by a CHC must be reported in writing to the Medical Division's Program Director for Community Health Centers. Any additions to the scope of services must be approved in writing by the Program Director before they are reimbursable by the Department. Deletions of services may result in review of the CHC by the Department in order to determine whether the CHC still meets the requirements for certification set forth in Section 405.403.

405.404: Administrative Requirements

A CHC must meet the administrative requirements specified in this section in order to receive certification as outlined in Section 405.403.

(A) Licensing. The CHC must be licensed as a clinic by the Massachusetts Department of Public Health or must operate under a hospital license issued by the Department of Public Health. For the purposes of these regulations, the term "licensee" means the entity named in the license issued by the Department of Public Health.

(B) Nonprofit Status. The CHC must be a nonprofit organization.

(C) Staffing.

(1) The CHC must employ an on-site manager who is qualified by training or experience to serve as the administrator of the CHC. He shall be responsible to the licensee for both the management and administration of CHC services, for carrying out policies established or approved by the licensee, and for ensuring that the CHC complies with these regulations.

(2) The CHC shall employ a professional-services director who is a health practitioner qualified by training or experience to direct and evaluate the provision of health services in the CHC. For the purposes of these regulations, the term "health practitioner" means an individual who can diagnose and treat medical problems, whether by authority of his own license or by the delegated authority of a licensed medical professional. The professional-services director shall supervise the staff members providing health services and shall ensure that treatment and care are both adequate and appropriate to the needs of recipients and are in compliance with these regulations. He must be either on site or on call at all times that the CHC is in operation.

(3) The same individual may serve as both the manager and the professional-services director, if this individual meets the requirements in Subsections (C)(1) and (2) above.

(D) Minimum Hours. The CHC must be open for the delivery of medical services to the public on a regular schedule for a minimum of 20 hours per week.

(E) Governing Board. The CHC must have a governing or advisory board that includes at least one person who uses the services of the CHC on a regular basis. This person may not be employed by the CHC or the licensee while he is a member of the board. Matters subject to review by the board must include, but are not necessarily limited to, scope of services, budget, personnel policies, and program evaluation.

405.405: Physician Time Required on Site

A CHC must have at least one licensed physician on site during the CHC's hours of operation to treat medical problems outside the expertise of other health practitioners on the CHC's staff. This physician may leave the CHC for limited periods of time to visit CHC patients in their homes, in hospitals, or in nursing homes; but he must be on call to the CHC during such periods. CHCs that are in isolated rural areas where no licensed physician is available on a regular basis within a 20-mile radius and that have a licensed physician on call during all hours of operation may apply to the Medical Division's Program Director for Community Health Centers for a waiver of this requirement.

405.406: Medical Services Required on Site

A CHC must provide on site the medical services specified in this section. It is not necessary that all of these services be available during all hours of the CHC's operation, but all must be available to recipients on a regularly scheduled basis with sufficient frequency to ensure access to care and continuity of care. In unusual circumstances (for example, if the CHC does not serve patients of the particular age group), the Medical Division's Program Director for Community Health Centers may waive the requirements for pediatric and/or obstetrical/gynecological services (see Subsections (A) and (C) below).

(A) Pediatric Services. A CHC must provide pediatric services.

(B) Internal Medicine. A CHC must provide internal medicine services.

(C) Obstetrics/Gynecology. A CHC must provide obstetrical and gynecological services.

(D) Health Education. A CHC must provide health education designed to prepare recipients for their participation in and reaction to specific medical procedures, and to instruct

recipients in self-management of medical problems and in disease prevention. Health education may be provided by any health practitioner or other individual approved by the professional-services director of the CHC as possessing the qualifications and training necessary to provide health education to recipients.

(E) Medical Social Services. A CHC must provide medical social services designed to assist recipients in their adjustment to and management of social problems resulting from medical treatment, specific disease episodes, or chronic illness. Medical social services may be provided by any health practitioner or other individual approved by the professional-services director of the CHC as possessing the qualifications and training necessary to provide medical social services to recipients.

(F) Nutrition Services. A CHC must provide counseling in the purchase, preparation, and consumption of proper nutrients to recipients who have been determined to require such counseling because of their health problems or because they have a high potential for developing health problems that might be avoided or made less severe through proper nutrition. Each CHC must employ a nutrition professional who either possesses a bachelor's or master's degree in public-health nutrition, community nutrition, or human nutrition, or who is currently registered by the American Dietetic Association as a registered dietitian. The nutrition professional is responsible for planning, directing, and evaluating the nutrition services provided at the CHC, for providing inservice nutrition education to the CHC's staff, for supervising nutrition aides, if any, for providing consultation to practitioners and other staff members of the CHC, and for counseling recipients referred for nutrition information. The nutrition professional must be on site at least one day per calendar month.

405.407: Medical Services Required on Site or by Referral

All of the services listed in this section must be provided on site or, alternatively, through a referral network. In order to provide on site any of the services listed below, with the exception of audiology, electrocardiogram, laboratory, and radiology services, the CHC must obtain the prior written approval of the Medical Division's Program Director for Community Health Centers. All services provided on site must be in compliance with the applicable Medical Assistance Program regulations for each service. All services provided by referral must be based on written or verbal agreements between the CHC and each referral provider that ensure continuity

of care, exchange of relevant health information such as test results and records, and avoidance of service duplication. Each referral provider must be a participating provider in the Medical Assistance Program. All referrals must include follow-up to ensure that the referral process is completed successfully. Services that must be provided on site or through the referral network are the following:

(A) audiology services;

(B) Chapter 766 core evaluations;

(C) dental services;

(D) electrocardiogram (EKG) services;

(E) home health services;

(F) laboratory services;

(G) medical specialty services;

(H) mental health services including psychological testing;

(I) occupational therapy services;

(J) pharmacy services;

(K) physical therapy services;

(L) podiatry services;

(M) radiology services;

(N) speech therapy services; and

(O) vision care services.

405.408: Continuity of Care and Case Management

(A) Continuity of Care. A CHC must maintain continuity of care and a case-management approach to providing health care to recipients. Continuity of care ensures that a recipient will always be seen by a health practitioner knowledgeable about his case. Continuity of care can be accomplished through the use of health-care teams or by another method that ensures that more than one health practitioner is knowledgeable about each recipient's case. Mere access to medical records by all practitioners who deliver services to a recipient will not suffice as a means of complying with this requirement.

(B) Case Management. A case-management approach ensures that a recipient will be assigned to or will choose one or more health practitioners who will provide the services listed in Section 405.406 and either will provide directly or arrange, monitor, and document the provision of the services listed in Section 405.407 and any optional services on a continuing basis.

405.409: Recordkeeping Requirements

(A) A CHC must comply with the Department's recordkeeping regulation contained in 106 CMR 450.205. In addition, each recipient's medical record must include the reason for each visit and the data upon which the diagnostic impression or statement of the recipient's problem is based, and must be sufficient to justify any further diagnostic procedures, treatments, and recommendations for return visits or referrals. Specifically, a medical record must include, but shall not be limited to:

(1) the date of each service;
(2) the recipient's name and date of birth;
(3) the signature and title of the person performing the services;
(4) the recipient's medical history;
(5) the diagnosis or chief complaint;
(6) clear indication of all findings, whether positive or negative, on examination;
(7) any medications administered or prescribed, including strength, dosage, and regimen;
(8) a description of any treatment given;
(9) recommendations for additional treatments or consultations, when applicable;
(10) any medical goods or supplies dispensed or prescribed;
(11) any tests administered and their results;
(12) a notation of hospitalization ordered by a CHC practitioner and discharge summaries from such hospitalization; and
(13) notations of all referrals and results of referrals, including the referral provider's diagnoses, treatment plans, test results, and medical outcomes.

(B) Basic data collected during previous visits (for example, identifying data, chief complaint, history) need not be repeated in the recipient's medical record for subsequent visits. However, data that fully document the nature, extent, quality, and necessity of care furnished to a recipient must be included for each date of service and/or service claimed for payment, along with any data that update the recipient's

medical course. It is not necessary to include a full medical history in the medical record for any recipient who is seen by the CHC while he is temporarily in the CHC's service area and who the CHC believes will not return.

(C) For hospital visit services, there must be an entry in the hospital medical record corresponding to and substantiating each hospital visit claimed for payment. An inpatient medical record shall be deemed to document services provided to recipients and billed to the Department if it conforms to and satisfies the medical records requirements set forth in the current Rules and Regulations for Hospitals in Massachusetts issued by the Massachusetts Department of Public Health. The CHC claiming payment for a hospital inpatient visit shall be responsible for the adequacy of the medical record documenting such visit. The physician must sign the entry in the hospital medical record that documents the findings of the comprehensive history and physical examination.

(D) Additional medical records requirements for other services can be found in the applicable sections of these regulations.

405.410: Coordination of Services

A CHC that provides any of the services listed in Sections 405.407 or 405.471 must coordinate these services with all other services at the CHC. Such coordination includes at a minimum:

(A) one central medical record for each recipient in which all medical and health-care services are recorded;

(B) medical accountability to the CHC's professional-services director;

(C) administrative accountability to the CHC's manager;

(D) participation in the CHC's quality-assessment program (if the special group of services has its own plan for quality assessment, this plan must be approved by the professional-services director who shall also receive progress reports);

(E) regular participation in the CHC's staff meetings and other appropriate activities by those professionals responsible for directing special services; and

(F) familiarization of all personnel employed through special programs with the CHC's policies, procedures, staff, and scope of services.

405.411: Translation Services

A CHC must employ at least one practitioner or translator conversant in the primary language of each substanial population of non-English-speaking recipients that uses the CHC on a regular basis. A CHC must be responsive to the needs of the non-English-speaking population living within its service area.

405.412: Medical/Emergency Backup Services

A CHC must provide either:

(A) 24-hour-a-day on-site medical or emergency services or both; or

(B) an after-hours telephone service, and have a written agreement with a provider of 24-hour-a-day medical or emergency service or both.

A tape-recorded telephone message instructing recipients to call a hospital emergency room will not suffice as compliance with this requirement.

405.413: Quality-Assessment Program

A CHC must have in effect a program for internal quality assessment that is based on written policies, standards, and procedures, and that includes the following:

(A) a review of the CHC's performance including, but not necessarily limited to, such aspects as adequacy of record-keeping, referral procedures and follow-up, medication review, quality of patient care, and identification of deficient areas of performance;

(B) recommendations for correcting the deficiencies identified in the review; and

(C) a review of the corrective action previously recommended.

These reviews shall be conducted at least twice a year by a committee composed of the professional-services director, representatives of each professional discipline on the CHC's staff, consumers, and, if possible, health professionals not employed at the CHC. Activities of the committee shall be documented in minutes or a report and made available to the Department upon request.

405.414: Maximum Allowable Fees

The Massachusetts Rate Setting Commission determines the maximum allowable fees for CHC services. Payment is always subject to the conditions, exclusions, and limitations set forth in this Chapter 405.000.

(A) Deliveries. The maximum allowable fee for a delivery shall be the lowest of the following:

(1) the CHC's usual and customary fee;
(2) the CHC's actual charge submitted; and
(3) the maximum allowable fee listed in the applicable Rate Setting Commission fee schedule, subject to any fee reductions enacted into law.

(B) Other Services. The maximum allowable fees for all CHC services other than deliveries shall be the lower of the following:

(1) the amount specified in the applicable fee schedule; and
(2) the CHC's usual and customary fee.

(106 CMR 405.415 through 405.420 Reserved)

405.421: Visits: Definitions

(A) Individual Medical Visit. An individual medical visit is a face-to-face meeting at the CHC between a recipient and a physician, nurse practitioner, registered nurse, or physician assistant for purposes of medical examination, diagnosis, or treatment. This visit is not to be used for mental health services.

(B) Individual Mental Health Visit. An individual mental health visit is a face-to-face meeting at the CHC between a recipient and a psychiatrist for purposes of mental health examination, diagnosis, or treatment. A mental health visit conducted by a person other than a psychiatrist (for example, a psychologist, nurse, physician assistant, social worker, or counselor) is not reimbursable.

(C) Group Clinic Visit. A group clinic visit is a group meeting conducted by a physician, nurse practitioner, registered nurse, or physician assistant for purposes of preparing recipients for their participation in and reaction to specific medical procedures, instructing recipients in self-management of medical problems, or presenting techniques for disease prevention. The size of the group shall be no more than 15 persons. (The purpose of this subsection is not to require that all instructional group sessions for recipients

be carried out by the health professionals listed above, but rather to allow payment for group visits when they are conducted by personnel who would otherwise be conducting revenue-producing visits. A group visit conducted by other kinds of professionals (for example, social workers, counselors, or nutritionists) is not reimbursable as a group clinic visit.)

(D) Hospital Visit. A hospital visit is a visit by a physician to a recipient who has been admitted to a hospital by a physician on the CHC's staff.

(E) Nursing Home Visit. A nursing home visit is a visit by a physician to a recipient who has been admitted to a nursing home, extended care facility, or convalescent or rest home.

(F) Home Visit. A home visit is a face-to-face meeting between a recipient and a physician, physician assistant, nurse practitioner, or registered nurse in the recipient's residence for purposes of examination, diagnosis, or treatment. A home visit must be used to deliver episodic care in the recipient's home when a health practitioner has determined that it is not advisable for the recipient to visit the CHC. The medical record must contain documentation of the reasons necessitating a home visit. A home-bound recipient with chronic medical and nursing-care needs must be referred to a Medicare-certified home health agency.

405.422: Visits: Fee Schedule

When claiming payment for visits, a CHC must bill according to the following fee schedule. A visit during which a recipient sees more than one professional for the same medical problem or general purpose must be claimed as only one visit.

Service Code	Service Description	Allowable Fee
033300	Individual medical visit	fee set by Rate Setting Commission for each center
033310	Individual mental health visit	fee set by Rate Setting Commission for each center
033343	Group clinic visit	1/5 of fee for individual medical visit
019071	Initial hospital visit: a comprehensive history and physical exam-	$ 17.00

	ination, including initiation of diagnostic and treatment program and preparation of hospital records	
019074	Subsequent or follow-up hospital visit: limited examination, evaluation, and treatment	9.50
019053	Nursing home visit: a regular nursing home visit for a brief, limited, or intermediate examination, evaluation, and/or treatment, same or new illness, first recipient seen in nursing home	11.50
019058	Each additional recipient seen during a nursing home visit	5.50
033340	Home visit	11.00

405.423: Deliveries: Definition

The Department will pay for a delivery performed in a hospital by a physician or, in the case of a pelvic delivery, by a certified nurse midwife (CNM), when the physician or CNM is employed by the CHC. A claim for payment for the services of only one practitioner may be submitted by the CHC (that is, a CHC may not submit two claims--one for a physician and one for a CNM). When the CHC submits a claim to the Department for payment for a delivery, another claim must not be submitted by the individual practitioner.

405.424: Deliveries: Fee Schedule

The services listed below are subject to and reflect the 15-percent reduction, as required by the Legislature, of the fees in effect in June 1975 for physician services.

Service Code	Service Description	Allowable Fee
033001	Pelvic delivery (exclusive of prepartum and postpartum care)	$145.50
033002	Low cervical (low uterine segment) Caesarean section (exclusive of prepartum and postpartum care)	292.00
033003	Classic Caesarean section (exclusive of prepartum and postpartum care)	292.00

033004	Extraperitoneal Caesarean section (Waters, Latzko)	292.00
033005	Caesarean section and hysterectomy (Porro)	292.00
033006	Caesarean section with total hysterectomy (not Porro)	316.80
033007	Vaginal Caesarean section	244.00

(106 CMR 405.425 through 405.430 Reserved)

405.431: Laboratory Services: Request-for-Services Requirement

In order for a CHC to be paid for any laboratory service, a written request for that service from a physician, dentist, nurse practitioner, or physician assistant must be present in the recipient's medical record.

405.432: Laboratory Services: Eligibility to Provide Services

A CHC is eligible to bill the Department for the laboratory tests listed in the laboratory fee schedule only under all of the following conditions.

(A) The laboratory tests are performed in the CHC.

(B) The tests are performed on properly and regularly calibrated equipment, and daily controls are carried out.

(C) The laboratory participates in an external proficiency-testing program for any tests it is performing. It must be demonstrated that the CHC's laboratory performance is satisfactory according to the proficiency-testing program guidelines. The following proficiency-testing programs are acceptable:

(1) the American Association of Bioanalysts Program;
(2) the State Laboratory Improvement Program; and
(3) the College of American Pathologists Program.

Other proficiency-testing programs may be acceptable, but only upon the express written approval of the Medical Division's Program Director for Laboratory Services.

405.433: Laboratory Services: Fee Schedule Explanation

(A) The Department will not pay a CHC for the following services: routine specimen collection and preparation for the purpose of clinical laboratory analysis (for example,

venipunctures; urine, fecal, and sputum samples; Pap smears; cultures; and swabbing and scraping for removal of tissue); or such calculations as red cell indices, A/G ratio, creatinine clearance, and those ratios calculated as part of a profile. The Department will not pay a CHC for a service when the CHC bills separately for the professional component of that service. The Department will pay a CHC for the professional component of an anatomical service separately, as provided in the fee schedule (for example, bone marrow analysis, analysis of surgical specimen).

(B) A profile or panel test is defined as any group of tests, whether performed manually, automatedly, or semiautomatedly, that is ordered for a specified recipient on a specified day and has at least one of the following characteristics.

(1) The group of tests is designated as a profile or panel by the CHC performing the tests.

(2) The group of tests is one of the "other profiles" in Subsection 405.601(B)(2).

(3) The group of tests contains three or more tests from List A in Subsection 405.601(B)(1), even though the group may also contain tests not found in List A.

(4) The group of tests is performed by the CHC at a usual and customary fee that is lower than the sum of that CHC's usual and customary fees for the individual tests in that group.

In no event shall a CHC bill or be paid separately for each of the tests included in a profile test when a profile test has either been performed by that CHC or requested by an authorized person.

(C) Some services listed in the fee schedule are designated "I.C.", an abbreviation for individual consideration. This means that a specific fee could not be established. The payment for an I.C. service will be determined by the Department's professional advisors based on the name of the test entered on the claim form.

(D) A CHC must not bill for a visit under Section 405.421 when a recipient is being seen for laboratory services only.

405.434: Laboratory Services: Services Performed by Outside Laboratories

(A) A CHC may not bill the Department for laboratory services provided outside the CHC. In this case, the testing laboratory should bill the Department directly for those services.

(B) When sending a specimen to an outside laboratory, the CHC must include the recipient's 17-digit Medicaid identification number and 2-digit suffix number, and the CHC's provider number.

(106 CMR 405.435 through 405.440 Reserved)

405.441: Radiology Services: Request-for-Services Requirement

In order for a CHC to be paid for any radiology service, a written request for that service from a physician, dentist, nurse practitioner, or physician assistant (including dental hygienist) must be present in the recipient's medical record.

405.442: Radiology Services: Eligibility to Provide Services

A CHC is eligible to bill the Department for diagnostic radiology services furnished to a recipient only under all of the following conditions.

(A) The radiology equipment used to perform the services must be located at the CHC, must be approved by the Massachusetts Department of Public Health, and must have been acquired in conformity with regulations of the Department of Public Health Certificate of Need Program.

(B) The radiology services must be performed at the CHC by a physician or radiologic technologist. A radiologic technologist is an individual who holds a current certificate of registration as a radiologic technologist issued by the American Registry of Radiologic Technologists or who is a graduate of a program in radiologic technology approved by the Council on Medical Education of the American Medical Association.

(C) A radiologist employed by the CHC must be certified by or eligible for examination by the American Board of Radiology, Inc.

(D) A radiologist employed by the CHC must interpret the results of the radiology service within four days after completion of the service.

(E) A radiologist must be present in the room if any service listed in Section 405.603 is being performed.

(F) The activities of the radiologic technologist must be supervised by a radiologist employed by the CHC.

405.443: Radiology Services: Fee Schedule Explanation

(A) The maximum allowable fees listed in Sections 405.602 and 405.603 include payment for both the technical and professional components of the radiology service. A CHC must not bill for the technical component separately.

(B) Radiology services that are not listed in Sections 405.602 or 405.603 are not reimbursable when furnished in a CHC. The CHC should refer a recipient to a hospital for such services.

(C) Some services listed in the fee schedule are designated "I.P.", an abbreviation for independent procedure. Radiology services that are performed at separate sittings on the same or different days are considered independent procedures. The CHC must not bill separately for a service listed as an I.P. service when this service is furnished as a portion of another radiology service at the same sitting.

(D) A CHC must not bill for a visit under Section 405.421 when a recipient is being seen for a radiology service only.

(106 CMR 405.444 through 405.450 Reserved)

405.451: Electrocardiogram (EKG) Services: Request-for-Services Requirement

In order for a CHC to be paid for any electrocardiogram (EKG) services, a written request must be made by a physician on the staff who will interpret or review the interpretation of this test. Documentation of the request must be kept in the recipient's medical record.

405.452: Electrocardiogram (EKG) Services: Eligibility to Provide Services

A CHC is eligible to bill the Department for electrocardiogram (EKG) services only under both of the following conditions.

(A) The CHC owns or rents its own EKG equipment.

(B) The EKG is taken at the CHC.

405.453: Electrocardiogram (EKG) Services: Fee Schedule Explanation

(A) The allowable fee listed in Section 405.454 for electrocardiogram (EKG) services includes payment for both the technical and professional components of the service. The test must be performed at the CHC and interpreted by a physician employed by the CHC.

(B) A CHC must not bill for a visit under Section 405.421 when a recipient is being seen for an EKG only.

405.454: Electrocardiogram (EKG) Services: Fee Schedule

Service Code	Service Description	Allowable Fee
019370	Electrocardiogram, with interpretation and report	$ 17.00

(106 CMR 405.455 through 405.460 Reserved)

405.461: Audiology Services: Request-for-Services Requirement

In order for a CHC to be paid for an audiology service, other than a hearing test performed as part of a Project Good Health health assessment (see Sections 405.481 through 405.491), a written request must be made by a physician, nurse practitioner, or physician assistant who has found some indication of a hearing problem. Documentation of the request and of the hearing problem must be kept in the recipient's medical record.

405.462: Audiology Services: Eligibility to Provide Services

(A) A CHC is eligible to bill the Department for a basic pure-tone (air and bone) evaluation by audiometer furnished to a recipient only under the following conditions.

(1) The CHC possesses on its premises a pure-tone audiometer, which must be calibrated at least once every six months. Records of calibrations must be kept and made available to the Department upon request. The machine must be placed and testing conducted in a quiet room.

(2) The person conducting hearing evaluations is trained to perform hearing tests with an audiometer.

(3) The quality of the tester's work is assessed at least twice a year by an audiologist certified by the American Speech and Hearing Association (ASHA) in accordance with ASHA standards. The audiologist may be a consultant to the CHC.

(B) A CHC is eligible to bill the Department for conducting acoustic impedance testing only under the following conditions.

(1) The test is conducted by an ASHA-certified audiologist on the premises of the CHC.

(2) The test is conducted by means of a functioning impedance bridge that is placed in a quiet room.

(C) If a problem or abnormality is detected or believed to be present after completion of either the basic pure-tone evaluation or the acoustic impedance test or both, the recipient must be referred to an otologist or an otolaryngologist for a more complete audiological evaluation and treatment as necessary.

405.463: Audiology Services: Fee Schedule Explanation

(A) Audiology services that are not listed in Section 405.464 are not reimbursable when furnished in a CHC.

(B) With the exception of impedance testing, audiologic tests listed in Section 405.464 are not reimbursable when performed on a child under the age of two years and six months.

(C) A CHC must not bill for a visit under Section 405.421 when a recipient is seen for audiology services only.

405.464: Audiology Services: Fee Schedule

Service Code	Service Description	Allowable Fee
019350	Audiometric hearing test, pure-tone, air only	$ 5.50
019352	air and bone, with or without masking	16.00
109369	Impedance testing, complete battery	18.00

(106 CMR 405.465 through 405.470 Reserved)

405.471: Optional Reimbursable Services

A CHC may elect to provide the following services on site or by referral, but it is not required to do so under these regulations. In order to provide on site any of the services listed below, the CHC must obtain the prior written approval of the Medical Division's Program Director for Community Health Centers:

(A) day habilitation;

(B) family planning;

(C) nursing home primary care (A CHC may apply to the Long-Term Care Unit of the Medical Division for a separate contract to participate in the Long-Term Care Facility Primary-Care Program. Such a contract allows nurse practitioners and physician assistants employed by the CHC to furnish care to recipients in nursing homes.);

(D) psychiatric day treatment; and

(E) speech and hearing services.

(106 CMR 405.472 through 405.480 Reserved)

405.481: Project Good Health Services: Introduction

(A) Legal Basis. Federal law governing Medical Assistance Programs requires the establishment of a program of Early and Periodic Screening, Diagnosis and Treatment (EPSDT) for persons under the age of 21 who are eligible for Medical Assistance (see 42 U.S.C. 1396d(a)(4)(b) and 42 CFR 441.50). Project Good Health (PGH) is the name given to the EPSDT program established in Massachusetts. The Department pays for PGH services provided to Medical Assistance recipients who are under the age of 21, including those who are parents. Sections 405.481 through 405.491 establish the regulations governing CHCs that provide PGH services.

(B) Program Objectives. The objectives of PGH are:
(1) to provide to eligible persons comprehensive and continuous health care designed to prevent illness and disability;
(2) to ensure early detection and prompt treatment of health problems before they become chronic or cause irreversible damage; and
(3) to create an awareness of the availability and value of preventive health-care services.

405.482: Project Good Health Services: Definitions

The following definitions apply to PGH services.

(A) Health Assessment -- the provision of screening procedures appropriate to the recipient's age and medical history, as indicated by the Medical Protocol and Periodicity Schedule.

(B) Medical Protocol and Periodicity Schedule -- a schedule (see Section 405.484) developed by the Department in consultation with the Massachusetts Chapter of the American Academy of Pediatrics that consists of screening procedures arranged according to the intervals or age levels at which each procedure is to be carried out. Any deviation from the Medical Protocol and Periodicity Schedule must be documented according to Subsection 405.485(B).

(C) PGH Referral -- a recommendation by the screening CHC to a PGH recipient that the recipient return to the screening CHC or see another provider for any additional test, diagnosis, or treatment indicated by the screening. The transmission of a specimen to a laboratory does not constitute a referral.

405.483: Project Good Health Services: Provider Cooperation with PGH Specialists

(A) PGH Specialists. PGH specialists are employees of the Department who inform recipients and providers about PGH, assist recipients in scheduling and keeping appointments for health assessments and for further diagnosis and treatment, and follow up to ensure that services have been received.

(B) Provider Cooperation.

(1) Federal law mandates that recipients who have requested assistance in obtaining medical care from the Department or a screening provider receive health assessments, diagnosis, and treatment within defined time periods. To ensure the Department's compliance with these time limits, the PGH specialist must follow up all health assessments the Department has arranged for by obtaining the information listed in Subsections (1)(a) through (c) below. A CHC must furnish the following information concerning each claim for PGH services if requested by the PGH specialist in its area:

(a) whether the health-assessment appointment was kept;

(b) whether a referral was made for further diagnosis and treatment; and

(c) if known, the date of the referral appointment.

(2) Once a CHC has submitted a claim for PGH services, the CHC must furnish health assessments for all recipients referred to it by the Department until that CHC notifies the Department's Medical Division in writing that it no longer intends to provide PGH services.

(C) Disclosure Requirement. Recipients must be informed by the CHC that information about their medical care will be furnished to the Department.

405.484: Project Good Health Services: Medical Protocol and Periodicity Schedule

Payment for PGH services is based upon the performance and documentation of the procedures listed in the Medical Protocol and Periodicity Schedule herein. The Schedule provides for basic preventive care and identifies recipients who require further diagnosis of suspected or actual health problems, treatment, or both. Explanations of procedures that appear in the Schedule and the information that must be maintained in the medical record to substantiate the performance of such procedures appear below.

(A) (Newborn) Initial History and Physical Examination -- documenting either in the CHC's medical record or in the hospital chart an examination of the newborn.

(B) (Newborn) Discharge History and Physical Examination -- documenting either in the CHC's medical record or in the hospital chart the discharge history and physical examination of the newborn.

(C) Health History -- recording in the medical record the family health history, baseline data on the recipient if not recorded previously, growth and development history, known reactions to medications and allergies, and pertinent information about previous illnesses, hospitalizations, and other medical and psychosocial problems.

(D) Interval History -- updating previously collected health history in the medical record with any illnesses, diseases, or medical problems experienced by the recipient since his last visit.

(E) Comprehensive Physical Examination -- documenting the findings of an unclothed physical examination including a complete systems review pertinent to the age of the recipient, fundoscopic examination of the eyes for recipients over five years of age, and observation of the teeth and gums for recipients three years of age or older.

(F) Developmental Assessment -- the combined observations by the recipient's parent or guardian and by the CHC of the recipient's current levels of functioning in the following areas, as appropriate to the recipient's age:

(1) gross motor development, including strength, balance, and locomotion;
(2) fine motor development, including eye-hand coordination;
(3) language development, including expression, comprehension, and articulation;
(4) self-help and self-care skills;
(5) social interaction and emotional development; and
(6) cognitive skills, including problem-solving and reasoning abilities.

(G) Nutritional Status Assessment -- the evaluation of the recipient's nutritional health in light of dietary practice and the entire health assessment (that is, history, physical examination, height and weight measurements, and laboratory tests) and documentation of any nutritional disturbance or dysfunction.

(H) Appropriate Immunizations -- the administration of injections and serums in accordance with the recommendations of the Massachusetts Department of Public Health and the American Academy of Pediatrics.

(I) Gross Hearing and Vision Tests -- the combined observations by the recipient's parent or guardian and by the CHC of the recipient's response to sound and ability to follow moving objects visually.

(J) Blood Pressure -- a standard procedure of the physical examination for recipients three years of age or older.

(K) Hearing Test (Audiometer) -- audiometric testing at the following frequencies: 500 Hz, 1000 Hz, 2000 Hz, and 4000 Hz.

(L) Vision Test -- testing by the Snellen chart, Titmus machine, or equivalent.

(M) PGH Education and Counseling -- educating and counseling the recipient, or his parent or guardian, in matters appropriate to the recipient's age (for example, nutrition, growth and development, tobacco, drugs, and sexuality).

(N) Assessment of Mental and Emotional Health -- the collaboration by the CHC, the recipient's parent or guardian, and the recipient in evaluating the recipient with respect to the following:

(1) the potential presence of learning disabilities;
(2) peer relations; and
(3) problems, especially depression, in psychological and psychiatric areas.

(O) Pelvic Examination -- documenting the general and specific condition of genitalia and internal reproductive organs. Documentation includes both normal and abnormal findings for the initial pelvic examination and any abnormalities found thereafter.

(P) EP -- the erythrocyte protoporphyrin method of testing for lead poisoning and iron deficiency.

MEDICAL PROTOCOL AND PERIODICITY SCHEDULE

RECOMMENDED AGE

SCREENING PROCEDURES	Newborn	2-6 wks	8-10 wks	4 mos	6 mos	9 mos	1 yr	15 mos	20 mos	2 yrs	30 mos	3 yrs	4 yrs	5 yrs	6 yrs	7 yrs	8 yrs	9 yrs	10-11 yrs	12-13 yrs	14-15 yrs	16-17 yrs	18-19 yrs	20 yrs
Initial history and physical examination	1																							
Discharge history and physical examination	1																							
Health history		2	2	2	2	2	2	2	2	2	2	2	2	2	2	2	2	2	2	2	2	2	2	
Interval history			1	1	1	1	1	1	1	1	1	1	1	1	1	1	1	1	1	1	1	1	1	1
Comprehensive physical exam		1	1	1	1	1	1	1	1	1	1	1	1	1	1	1	1	1	1	1	1	1	1	1
Developmental assessment		1	1	1	1	1	1	1	1	1	1	1	1	1	1	1	1	1	1	1	1	1	1	1
Nutritional status assessment		1	1	1	1	1	1	1	1	1	1	1	1	1	1	1	1	1	1	1	1	1	1	1
Appropriate immunizations		1	1	1	1	1	1	1	1	1	1	1	1	.1	1	1	1	1	1	1	1	1	1	1
Hearing/vision tests (gross)		1	1	1	1	1	1	1	1	1	1	1												
Blood pressure												1	1	1	1	1	1	1	1	1	1	1	1	1
Hearing test (audiometer)															4					4				4
Vision test													1			3			4		3			5
PCH education and counseling	10	10	10	10	10	10	10	10	10	10	10	10	10	10	10	10	10	10	10	10	10	10	10	10
Mental and emotional health status assessment																			1	1	1	1	1	1
Pelvic examination																					9	9	1	1
Hematocrit or hemoglobin							2	1																
EP or blood lead							1	6		3		6		3										
TB test							1								4						3			
Urinalysis and/or culture (if indicated)													1	3	1			1	1	1	1	1	1	1
Cholesterol-if history indicates											1													
Sickle cell test																				7				
Pap smear																					8	8	1	1
GC culture																					9	9	1	1
Serology																					9	9	9	9

Legend

1. The procedure must be done at this age.
2. The procedure must be done if not done previously.
3. The procedure must be done if not done during the last examination age on the schedule.
4. The procedure must be done if not done during the last two examination ages on the schedule.
5. The procedure must be done if not done during the last three examination ages on the schedule.
6. The EP or blood lead test should be performed if the child lives in a city that has a population over 100,000 and if medically necessary.
7. This procedure should be performed only once and only if indicated by ethnicity.
8. This procedure must be performed if a pelvic examination is performed at this visit.
9. This procedure is optional depending on the maturity level and sexual activity of the recipient.
10. This procedure should be done if appropriate.

405.485: Project Good Health Services: Description of Health Assessments

The health assessments described in this section are reimbursable when provided by a physician or by a nurse practitioner or physician assistant under a physician's supervision.

(A) PGH Health Assessment. A CHC may claim payment using Service Code 033350 for a PGH health assessment only if all the screening procedures in the Medical Protocol and Periodicity Schedule that correspond to the recipient's age have been performed. While the screening procedures are based upon a presumption of regular contact with health-care providers, many recipients have infrequent attention paid to their health-care needs and will need additional screening procedures to bring them up to date. In such a case, it is the CHC's responsibility to furnish those additional screening procedures necessary to bring the recipient up to date with his preventive health care according to the Medical Protocol and Periodicity Schedule. The CHC may make a screening referral to another provider if the CHC is unequipped to perform a test (for example, if the CHC does not have an audiometer and an audiometric test is required). However, in every case, all required screening procedures must have been performed and all results received in order for the CHC to claim payment for a PGH health assessment.

(B) PGH Health Assessment with Special Circumstances. A CHC may claim payment using Service Code 033352 for a PGH health assessment with special circumstances only in the following situations: a screening procedure has been omitted from the health assessment; or the results of laboratory tests or other referred screening procedures were not available within 30 days (see Subsections (1) and (2) below). The Department will review individually all claims for PGH health assessments with special circumstances to determine whether payment will be made. All claims for such health assessments based on the omission of a medically unnecessary screening procedure will be reviewed by a physician.

(1) Omission of a Procedure. A CHC may omit a procedure from a health assessment only in the following situations.

(a) Procedure Was Not Medically Necessary. If the person performing the health assessment omitted a screening procedure from a PGH health assessment because, in his professional judgment, the procedure was not medically necessary, the CHC must include with the claim for payment a statement citing the omitted procedure and the reason that it was not medically necessary. If the pro-

cedure was omitted because it was performed earlier, the date of such procedure must be included in the statement. For the purposes of this subsection, nonperformance of a procedure in the Medical Protocol and Periodicity Schedule that has the legend number 6, 7, 8, 9, or 10 corresponding to the recipient's age is not considered to be an omission, since such nonperformance is based upon factual determination rather than medical judgment.

(b) Procedure Was Impossible to Perform. If the person performing the health assessment omitted a screening procedure from a PGH health assessment because it was impossible to perform, the CHC must include with the claim for payment a statement citing the omitted procedure and the reason that the procedure was impossible to perform. If the procedure was impossible to perform because the recipient refused to cooperate, the CHC must describe in the statement its efforts to overcome the problem.

(2) Results of Referred Screening Procedure Not Available within 30 Days. If a CHC did not know the results of a laboratory test or other referred screening procedure within 30 days after the health assessment, the CHC must include with the claim for payment a statement that the laboratory or other provider has not returned the results and citing which results are outstanding.

405.486: Project Good Health Services: Dental Care

The screening CHC must encourage the recipient to seek regular dental care, including annual examinations, preventive services, and treatment as necessary, from a dental provider. The Department will inform recipients three years of age or older, or their parents or guardians, about available dental care and will offer assistance in scheduling and keeping appointments with dental providers.

405.487: Project Good Health Services: Diagnosis and Treatment

(A) For any problem that requires further diagnosis or treatment after the health assessment, the CHC either must request that the recipient return for another appointment or must refer the recipient to another provider. Federal regulation mandates the time limits within which screening, diagnosis, and treatment must be performed. Therefore, the request or the referral must be made immediately or as soon as the CHC obtains the screening result indicating a need for referral.

(B) When making a referral to another provider, the screening CHC must give to the recipient or to the recipient's parent or guardian the name and address of an appropriate provider.

(C) The screening CHC must establish a procedure to obtain a report of the results of diagnosis and treatment.

(D) If a CHC knows of any reason that a recipient might not make or keep an appointment for further diagnosis and treatment, such as a need for transportation, translation, or child care, the CHC must contact the PGH specialist in its area for assistance. For a list of locations and telephone numbers of PGH specialists, see Appendix D of the Community Health Center Manual.

405.488: Project Good Health Services: Claims for Health Assessments

(A) Fees for Health Assessments. The fee schedule in Subsection (E) below was adopted by the Massachusetts Rate Setting Commission for PGH health assessments furnished in accordance with the Medical Protocol and Periodicity Schedule and with these PGH regulations.

(B) Service Limitations. For each recipient from birth through nine years of age, a CHC may claim only one health assessment per age level in the Medical Protocol and Periodicity Schedule. For each recipient aged ten years through 20 years, a CHC may claim only one health assessment per year. Additional visits for high-risk recipients are not considered to be PGH health assessments but are reimbursable according to the fee schedule in Section 405.422.

(C) Claims for Health Assessment of a Newborn. In order to be paid for a PGH health assessment of a newborn, the person performing the health assessment must have visited the newborn at least twice before the newborn leaves the hospital. The first visit, for an initial history and physical examination, is reimbursable as an initial hospital visit (see Section 405.422) and not as a PGH health assessment. The discharge visit, for a discharge history and physical examination, is reimbursable as a PGH health assessment, in accordance with Subsections (D) and (E) below. Additional visits for ill newborns are reimbursable as subsequent or follow-up hospital visits (see Section 405.422).

(D) Report Requirement. In order to claim payment for a PGH health assessment, a CHC must submit a completed PGH/EPSDT Claim Form and Medical Examination Report (MA-8P). The MA-8P is a form specifically designed to collect written documentation of the screening procedures provided and each result, including problems needing follow-up treatment, as required by federal EPSDT regulations. Instructions for obtaining and completing the MA-8P are located in Subchapter 5 of the

Community Health Center Manual.

(1) When submitting a claim for a health assessment with special circumstances, the CHC must attach its statement (see Subsection 405.485(B)) to the MA-8P form. (See the billing instructions in Subchapter 5 of the Community Health Center Manual.)

(2) If a nurse practitioner or physician assistant has performed the health assessment, this must be indicated in the appropriate space on the MA-8P form (see the billing instructions in Subchapter 5 of the Community Health Center Manual).

(E) Fee Schedule.

Service Code	Service Description	Allowable Fee
033350	PGH health assessment (MA-8P form required)	the fee for an individual medical visit plus $5.50
033352	PGH health assessment with special circumstances (MA-8P form required) (medical review)	the fee for an individual medical visit plus $5.50

405.489: Project Good Health Services: Claims for Laboratory Services

The following laboratory services, which are included in the Medical Protocol and Periodicity Schedule, are reimbursable in addition to the health assessment when performed in the CHC that furnished the health assessment. The fees for these laboratory services are located in Section 405.601. A CHC may not claim payment for any test until the results are known.

Service Code	Service Description
108112	Cholesterol, total
108665	Culture, GC (gonococcus culture)
108885	Culture, routine, any source
108379	Erythrocyte protoporphyrin
108368	Hematocrit (HCT)
108366	Hemoglobin (HGB), colorimetric
108260	Lead screening, blood
108920	Pap (Papanicolaou) smear; cytopathology smear; Gravlee jet washing
108653	Serology; rapid plasma reagin (RPR)
108442	Sickle cell preparation
108340	Triglycerides, blood
108708	Urinalysis, complete (includes dip stick and microscopic exam and specific gravity)
108873	Urinary dip stick (pH, blood, ketones, glucose, nitrites) per combination dip stick

405.490: Project Good Health Services: Claims for Audiometric Hearing Test

Payment for the audiometric hearing test, which is included in the Medical Protocol and Periodicity Schedule, is not included in the fee for a health assessment and should be claimed separately. The fee for the audiometric hearing test is located in Section 405.464.

Service Code	Service Description
019350	Audiometric hearing test, pure-tone, air only

405.491: Project Good Health Services: Recordkeeping Requirements

(A) Medical Records. A CHC must create and maintain a centralized record for every PGH recipient in its care, in accordance with Department regulations governing medical records generally (see Section 405.409). In addition, the record for each PGH recipient must contain documentation of the screening procedures listed in Subsections 405.484(A) through (P) as well as the following:

(1) the results of all laboratory tests;
(2) the name and address of each referral provider; and
(3) the date and results of each referral appointment, if the appointment was kept.

(B) Determination of Compliance with Medical Standards. The Department may review a CHC's medical records of PGH recipients to determine the necessity, propriety, and quality of the medical care furnished. These determinations will be made by medical professionals in accordance with 106 CMR 450.206. The Department may request review by the Massachusetts Chapter of the American Academy of Pediatrics, or other appropriate professional organization, for the purposes of making such determinations. This review will be considered before the Department proceeds with administrative action based on a determination of noncompliance with medical standards as defined in 106 CMR 450.204.

(106 CMR 405.492 through 405.600 Reserved)

405.601: Laboratory Fee Schedule

(A) Individual Tests. The following fee schedule lists the maximum allowable fees for individual tests.

Service Code	Service Description	Allowable Fee
108477	ABO and Rh genotype	$ 5.00
108476	ABO grouping	5.00
108055	Acetone, serum	2.00
108710	Acetone, urine	2.00
108886	Acid fast culture	10.00
108882	Acid fast direct smear (concentrated AF smear, sputum)	6.00
108293	Acid phosphatase	5.00
108200	ACTH, adrenocorticotropin by RIA	10.00
108707	Addis count (quantitative sediment analysis)	4.50
108981	Agar plate--sweat electrolytes, qualitative	5.00
108460	Agglutination febrile per antigen	5.00
108486	Agglutinins, cold	5.00
108062	Albumin, chemistry	4.00
108712	Albumin, qualitative, urine	1.00
108711	Albumin, quantitative (Esbach)	4.00
108063	Alcohol, ethyl, methyl, isopropyl	10.00
108067	Aldolase	8.00
108767	Aldosterone, urine, RIA	10.00
108797	Aldosterone secretory rate	40.00
108295	Alkaline, phosphatase (blood)	5.00

Service Code	Service Description	Allowable Fee
108296	Alkaline, phosphatase; fractionated (isoenzymes) (electrophoresis)	$ 15.00
108427	Alkaline, phosphatase stain leucocyte	12.00
108081	Alpha 1 antitrypsin	10.00
108718	Amino acid, urine chromotographic fractionation and quantitation	20.00
108074	Ammonia, quantitative	8.00
108969	Amniocentesis, spectrographic analysis	5.00
108079	Amniotic fluid surfactant shake test	5.00
108721	Amylase (diastase), urine	5.00
108075	Amylase, chemistry	5.00
108899	Anaerobic culture (neg.)	5.00
108220	Angiotensin, blood	10.00
108510	Antibodies, heterophile screening (includes mono-type test)	5.00
108467	Antibody, irregular identification	5.00
108523	Antibody, thyroglobulin or microsomal	6.00
108406	Anticoagulants, circulating	5.00
108133	Anticonvulsive blood panel by GLC (dilantin and phenobarbitol)	15.00
108470	Antideoxyribonuclease titer (DNA)	10.00
108462	Antimitochondrial antibodies (AMA)	6.00
108077	Antinuclear fluorescent antibodies (ANA)	10.00
108483	Anti Rh immunoglobulin testing (RhoGam type)	5.00
108956	Antismooth muscle antibody (ASMA)	6.00

Service Code	Service Description	Allowable Fee
108473	Antistreptolysin titer, ASO, ASOT, AST, ASL	$ 5.00
108724	Arsenic quantitative, urine	12.00
108167	Arterial blood by electrode and pO_2, pOO_2	4.00
108080	Ascorbic acid; vitamin C	6.00
108463	Autoantibody screening	6.00
108352	B_{12} vitamin	12.00
108084	Barbiturates, blood quantitative (GLC)	20.00
108083	Barbiturates, urine screen	6.50
108369	Basophil count	4.00
108215	Beta sub unit	10.00
108089	Bicarbonate	5.00
108604	Bile, fecal	1.00
108730	Bile pigments, urine	3.00
108088	Bilirubin, direct	5.00
108087	Bilirubin, total and fraction	5.00
108360	Bleeding time	3.50
108363	Blood count (RBC)	2.00
108364	Blood count (WBC)	2.00
108365	Blood count, differential	4.00
108884	Blood culture	9.00
108372	Bone marrow (interpretation only)	10.00
108092	Bromide	5.00
108330	Bromsulphophthalein (BSP)	5.00

Service Code	Service Description	Allowable Fee
108924	Buccal smear for chromosomal sex determination (Barr)	$ 6.00
108367	Buffy coat smear	3.00
108344	BUN; urea nitrogen	4.00
108536	C-1 esterase inhibitor	10.00
108537	C-3 complement	10.00
108538	C-4 complement	10.00
108093	Calcium, blood chemistry	5.00
108098	Calcium determination, ionized	15.00
108736	Calcium, qualitative, urine	4.00
108737	Calcium, quantitative, urine	5.00
108680	Calculus analysis, qualitative, chemical	10.00
108099	Carbon dioxide, chemistry	4.00
108154	Carbon dioxide content or combining power	4.00
108100	Carbon monoxide, blood	5.00
108507	Carcinoembryonic antigen (CEA) by radioimmunoassay	28.50
108101	Carotene, beta	5.00
108771	Catecholamines, fractionated, urine	25.00
108770	Catecholamines, urine, total	15.00
108361	CBC: complete blood count (includes differential, RBC, hematocrit, hemoglobin, white blood count, and indices)	7.00
108507	CEA: carcinoembryonic antigen radioimmunoassay	28.50
108926	Cell block	14.50

Service Code	Service Description	Allowable Fee
108952	Cell count and differential	$ 6.00
108951	Cell count, miscellaneous body fluids, except blood (e.g., CSF, joint, etc.)	2.00
108817	Centrifuging and mailing specimen	1.00
108103	Ceruloplasmin	6.00
108640	Chlorides, spinal fluid	5.00
108742	Chlorides, urine	5.00
108110	Chlorides, chemistry	5.00
108113	Cholesterol, ester	5.00
108112	Cholesterol, total	5.00
108114	Cholinesterase	8.00
108927	Chromosome analysis (karyotype)	5.00
108406	Circulating anticoagulants	5.00
108378	Clot retraction	3.50
108403	Coagulation time; L and W	3.50
108486	Cold agglutinin	5.00
108648	Colloidal gold	5.00
108361	Complete blood count (CBC) (includes WBC, RBC, hemoglobin, hematocrit, and differential indices)	7.00
108120	Congo red	.50
108500	Coombs, direct	5.00
108501	Coombs, indirect qualitative	5.00
108121	Copper, serum	5.00
108746	Copper, urine	10.00

Service Code	Service Description	Allowable Fee
108799	Cortisol, plasma	$ 10.00
108801	Cortisol, secretory rate	24.00
108129	CPK, isoenzyme	20.00
108485	C-reactive protein (CRP)	5.00
108122	Creatine, blood	5.00
108747	Creatine, urine	5.00
108123	Creatine phosphokinase (CPK)	8.00
108125	Creatinine, chemistry	5.00
108126	Creatinine clearance	10.00
108748	Creatinine, urine	5.00
108475	Crossmatch	3.00
108128	Cryoglobulin	5.00
108886	Culture acid fast, A.F.	10.00
108899	Culture anaerobic (neg.)	5.00
108889	Culture "B" strep throat	4.00
108884	Culture, blood	9.00
108887	Culture, fungus	7.00
108665	Culture, G.C. (gonococcus culture)	7.00
108885	Culture, routine, any source	5.00
108897	Culture and sensitivity, antibiotic	8.00
108898	Culture, sensitivity, and colony count	7.50
108888	Culture, urine (quantitative) with colony count	8.00
108130	Cyanide	10.00

Service Code	Service Description	Allowable Fee
108750	Cystine screening, qualitative	$ 5.00
108923	Cytopathology, fluid	8.00
108920	Cytopathology smear; Papanicolaou (Pap) smear; Gravlee jet washing	6.00
108922	Cytopathology smears other than genital	8.00
108905	Dark field examination	8.00
108752	Delta-amino-levulinic acid (ALA), urine	15.00
108761	Diacetic acid, qualitative, urine	7.00
108635	Diagnex blue, gastric analysis, tubeless	5.00
108721	Diastase, amylase, urine	5.00
108365	Differential blood count	4.00
108131	Digoxin, RIA	10.00
108132	Dilantin quantitative, blood (diphenylhydantoin)	16.00
108873	Dip stick, urine (pH, blood, ketones, glucose, nitrites) per combination dip stick	1.00
108605	Direct wet preparation	3.00
108470	DNA (antideoxyribonuclease titer)	10.00
108134	Doriden (glutethimide)	7.00
108408	Eosinophil count (EOS)	4.00
108379	Erythrocyte protoporphyrin	5.00*
108316	Estradiol by RIA	10.00

*Send to: State Lead Poison Prevention Program
305 South Street
Jamaica Plain, MA 02130

Service Code	Service Description	Allowable Fee
108214	Estriol, blood	$ 20.00
108783	Estrogens, urine, fractionated into estrone, estradiol, and estriol	30.00
108782	Estrogens, urine total, nonpregnant state	20.00
108320	Fasting blood sugar (FBS); glucose; sugar	5.00
108602	Fat, fecal or lipids (stain)	9.50
108135	Fatty acids, blood	8.00
108460	Febrile agglutination, per antigen	5.00
108954	Ferritin	5.00
108411	Fibrin (split products) (FSP)	5.00
108390	Fibrin stabilizing, factor XIII	8.00
108412	Fibrinogen, qualitative (F-Y test)	5.00
108413	Fibrinogen, quantitative	5.00
108534	Flocculation, STS (standard test for syphilis)	5.00
108893	Fluorescent beta strep. screening	5.00
108563	Fluorescent treponema antibodies, absorbed (FTA)	10.00
108138	Folic acid, vitamin M (folate level)	10.00
108795	Follicle stimulating hormone (FSH) by RIA; urinary pituitary gonadotropins	17.50
108332	Free thyroxine (includes thyroxine T_4)	20.00
108943	Frozen section	25.00
108887	Fungus culture	7.00
108140	Galactose	10.00

Service Code	Service Description	Allowable Fee
108146	Gamma-glutamyl transpeptidase (GGTP)	$ 5.00
108635	Gastric analysis, tubeless, diagnex blue	5.00
108631	Gastric analysis without histamine, routine	10.00
108984	Gastrin serum by RIA	10.00
108665	GC culture (gonococcus culture)	7.00
108179	Globulin, direct determination	6.00
108642	Glucose, spinal fluid	5.00
108320	Glucose; sugar; postprandial sugar; fasting blood sugar (FBS)	5.00
108864	Glucose; sugar, quantitative, 24-hour specimen	4.00
108322	Glucose tolerance (maximum of $20.00)	4.00/assay
108176	Glucose 6-phosphate-dehydrogenase (G-6-PD) quantitative	6.00
108175	Glucose 6-phosphate-dehydrogenase (G-6-PD) screen	5.00
108134	Glutethimide (doriden)	7.00
108976	Glycohemoglobin (Ha AIC)	15.00
108794	Growth hormone, GH or HGH, by RIA	10.00
108908	Guinea pig or small animal inoculation	5.00
108182	Haptoglobin	10.00
108725	Heavy metal, Reinsch test	5.00
108368	Hematocrit (HCT)	2.00
108765	Hemogentistic acid screen	9.00
108190	Hemoglobin electrophoresis, starch block	15.00

Service Code	Service Description	Allowable Fee
108183	Hemoglobin electrophoresis, paper or cellulose acetate	$ 15.00
108196	Hemoglobin CO, methemalbumin, methemoglobin spectroscopic	3.00
108186	Hemoglobin F (fetal) (chemical)	6.00
108366	Hemoglobin (HGB), colorimetric	2.00
108508	Hepatitis associated antigen (HAA, HBsAg)	10.00
108978	Herpes simplex titer	10.00
108510	Heterophile: antibodies, screening (includes mono-type test)	5.00
108513	Heterophile exclusion	9.00
108794	HGH growth hormone (GH) by RIA	10.00
108241	High-density lipoprotein (HDL)	10.00
108474	HLA B-27	20.00
108765	Homogentistic acid screen, urine	9.00
108236	Hydroxybutyric dehydrogenase (HBD)	8.00
108787	Hydroxycorticosteroids, reduced ketogenic Porter-Silber	10.00
108860	5-Hydroxyindoleacetic acid (5-HIAA), quantitative; serotonin	10.00
108810	Hydroxyproline, urine, free	15.00
108811	Hydroxyproline, urine, total	15.00
108812	Hydroxyproline, urine, free and total	30.00
108517	Immunodiffusion (IGg, IgA, IgE, IgM, IgD) (maximum of $45.00)	15.00 each
108515	Immunoelectrophoresis	25.00

Service Code	Service Description	Allowable Fee
108222	Insulin, blood	$ 10.00
108326	Insulin tolerance (includes injection)	7.50
108225	Iodine, butanol extractable (BIE, BEI)	7.00
108224	Iodine, protein bound (PBI)	6.00
108226	Iodine, urine	6.00
108098	Ionized calcium determination	15.00
108242	Iron	5.00
108246	Iron binding capacity, Irosorb (TIBC) (includes iron)	5.00
108424	Iron stain	6.00
108467	Irregular antibody identification	5.00
108129	Isoenzyme, CPK	20.00
108955	Joint fluid analysis, mucin test; ropes	3.00
108785	17-Ketogenic steroids	10.00
108790	17-Ketosteroids, total	10.00
108255	Lactic dehydrogenase (LDH)	5.00
108257	Lactic dehydrogenase isoenzyme; electrophoresis	5.00
108520	Latex fixation, RA	5.00
108522	Latex fixation, rheumatoid factor	5.00
108260	Lead screening, blood	1.00*
108816	Lead screening, urine	1.00*

*Send to: State Lead Poison Prevention Program
305 South Street
Jamaica Plain, MA 02130

Service Code	Service Description	Allowable Fee
108525	L.E. preparation, smear method	$ 5.00
108263	Leucine aminopeptidase (LAP), blood	5.00
108818	Leucine aminopeptidase (LAP), urine	5.00
108427	Leucocyte alkaline phosphatase stain	12.00
108265	Lipase	5.00
108602	Lipids or fat (stain)	9.50
108266	Lipids, total	7.00
108268	Lipoproteins (electrophoresis)	15.00
108270	Lithium, blood, quantitative	8.00
108525	Lupus erythematosus; LE preparation (smear method)	5.00
108219	Luteinizing hormone, blood (LH)	10.00
108271	Magnesium, blood	5.00
108275	Manganese, blood	6.00
108826	Mercury, screening, urine	15.00
108828	Metanephrine	15.00
108196	Methemalbumin, hemoglobin CO, methemoglobin spectroscopic	3.00
108523	Microsomal antibody or thyroglobulin antibody	6.00
108282	Mono test (rapid screening)	5.00
108269	Myoglobin electrophoresis	15.00
108833	Myoglobin screening	5.00
108957	Mysoline serum level (primidone)	16.00
108284	Nonprotein nitrogen (NPN)	4.00

Service Code	Service Description	Allowable Fee
108283	Nucleotidase	$ 5.00
108600	Occult blood	3.00
108705	Occult blood, urine	3.00
108286	Osmolality	5.00
108437	Osmotic fragility, red blood cell, incubation	5.00
108606	Ova and parasites	7.50
108837	Oxalates, urine	5.00
108920	Pap (Papanicolaou) smear; cytopathology smear; Gravlee jet washing	6.00
108237	Parathyroid hormone (PTH) (parathormone)	35.00
108450	Partial thromboplastin time (PTT)	11.00
108152	pCO_2 (gases)	4.00
108150	pH^1 (gases)	4.00
108843	Phenolsulfonphthalein (PSP), urine	6.00
108293	Phosphatase acid	5.00
108295	Phosphatase alkaline, blood	5.00
108296	Phosphatase alkaline, fractionated (isoenzymes) (electrophoresis)	15.00
108123	Phosphokinase, creatine (CPK)	8.00
108298	Phospholipids, blood	3.00
108300	Phosphorus	5.00
108607	Pin worm exam, Scotch tape, etc.	5.00
108206	Pituitary gonadotropins, blood, by RIA	10.00
108795	Pituitary gonadotropins, urinary (FSH), by RIA	17.50

Service Code	Service Description	Allowable Fee
108218	Plasma renin assay (renin, blood)	$ 20.00
108433	Platelet adhesiveness	5.00
108446	Platelet aggregation screening	6.00
108430	Platelet count (Rees-Ecker)	5.00
108165	pO_2 (gases)	4.00
108167	pO_2, pOO_2, and arterial blood by electrode	4.00
108850	Porphobilinogen	5.00
108852	Porphyrins, quantitative, including coporphyrin, uroporphyrin, and porphobilinogen	11.00
108301	Potassium (K), blood	5.00
108853	Potassium (K), urine	5.00
108881	Potassium hydroxide, wet mount, any source	3.00
108202	Pregnancy test, tube (U.C.G.)	5.00
108209	Pregnancy test, slide	5.00
108796	Pregnanediol, urine (chemical)	20.00
108800	Pregnanetriol, urine (chemical)	20.00
108957	Primidone (mysoline serum level)	16.00
108217	Progesterone, blood	10.00
108983	Prolactin	10.00
108302	Pronestyl	15.00
108855	Protein, Bence-Jones, urine	4.00
108224	Protein bound iodine (PBI)	6.00
108485	Protein, C-reactive (CRP)	5.00

Service Code	Service Description	Allowable Fee
108305	Protein, electrophoresis	$ 15.00
108645	Protein, quantitative, spinal fluid	4.00
108303	Protein, total	4.00
108434	Prothrombin time (activity) (PT)	5.00
108435	Prothrombin utilization (consumption)	6.00
108312	Quinidine, blood	20.00
108653	Rapid plasma reagin (RPR); serology	5.00
108398	Recalcification time	3.00
108437	Red blood cell, osmotic fragility, incubation	5.00
108363	Red blood count (RBC)	2.00
108436	Red cell fragility (Rumpel-Leede osmotic Sanford)	5.00
108218	Renin, blood (plasma renin assay)	20.00
108440	Reticulocyte count	4.00
108464	Rh titer, A, B and others, albumin or saline technic, each	5.00
108480	Rh typing	3.00
108520	Rheumatoid arthritis (RA); latex fixation	5.00
108483	RhoGam type (anti Rh immunoglobulin testing)	5.00
108530	Rubella, C-F test, single test	6.00
108528	Rubella, H.I., acute and convalescent (two tests, same recipient)	10.00
108527	Rubella, H.I., single sample	5.50
108313	Salicylates, blood	5.00

Service Code	Service Description	Allowable Fee
108858	Salicylates, quantitative	$ 5.00
108707	Sediment analysis, Addis count, quantitative	4.50
108441	Sedimentation rate; erythrocyte sedimentation rate (ESR); Wintrobe	5.00
108975	Semen analysis, complete (volume count, motility, differential)	8.00
108973	Semen analysis (including Huhner)	15.00
108897	Sensitivity and culture, antibiotic	8.00
108898	Sensitivity, culture, and colony count	7.50
108653	Serology; rapid plasma reagin (RPR)	5.00
108860	Serotonin; 5-hydroxy-indoleacetic acid (5-HIAA), quantitative	10.00
108335	SGOT transaminase	5.00
108337	SGPT transaminase	5.00
108442	Sickle cell preparation	6.00
108882	Smear, acid fast (AF), sputum, concentrated specimen	6.00
108654	Smear for bacteria (spinal fluid)	3.00
108924	Smear, buccal for chromosomal sex determination (Barr)	6.00
108367	Smear, buffy coat	3.00
108922	Smear, cytopathology, other than genital	8.00
108880	Smear, routine (initial miscroscopic examination)	3.00
108920	Smear, Pap (Papanicolaou); cytopathology smear; Gravlee jet washing	6.00
108862	Sodium (Na)	5.00

Service Code	Service Description	Allowable Fee
108863	Specific gravity, any method, urine	$ 2.00
108882	Sputum smear (acid fast smear)	6.00
108889	Strep throat culture "B"	4.00
108534	S.T.S. flocculation (standard test for syphilis)	5.00
108937	Surgical pathology, multiple specimens and/or extensive dissection with individual identification or unusual preparation	15.00
108936	Surgical specimen, gross	7.50
108934	Surgical specimen, gross and microscopic exam, per specimen	15.00
108981	Sweat electrolytes, qualitative agar plate	5.00
108980	Sweat electrolytes, quantitative sodium and chloride	10.00
108227	T-3 total (tri-iodo-thyronine)	10.00
108331	T-4 (thyroxine)	10.00
108324	Tegretol	15.00
108223	Testosterone, blood	25.00
108447	Thromboplastin generation time test (TGT); Hicks-Pitney test	8.00
108523	Thyroglobulin antibody or microsomal antibody	6.00
108233	Thyroid binding globulin	15.00
108234	Thyroid stimulating hormone (TSH)	10.00
108332	Thyroxine, free (includes thyroxine T_4)	20.00
108325	Tolbutamide tolerance (includes injection) (maximum of $20.00)	4.00/assay

Service Code	Service Description	Allowable Fee
108560	Toxoplasmosis test	$ 16.00
108335	Transaminase SGOT	5.00
108337	Transaminase SGPT	5.00
108340	Triglycerides, blood	10.00
108613	Trypsin, fecal	5.00
108234	TSH (thyroid stimulating hormone)	10.00
108202	UCG (pregnancy test, tube)	5.00
108999	Unlisted test	I.C.
108346	Urea clearance	5.00
108344	Urea nitrogen, blood (BUN)	4.00
108872	Urea nitrogen or uric acid; urine	5.00
108347	Uric acid, blood (SUA)	5.00
108708	Urinalysis, complete (includes dip stick and microscopic exam and specific gravity)	4.00
108873	Urinary dip stick (pH, blood, ketones, glucose, nitrites) per combination dip stick	1.00
108877	Urobilinogen, qualitative (Ehrlich test), urine	5.00
108876	Urobilinogen, quantitative (Watson), urine	3.00
108773	Vanilly-mandelic acid, quantitative, chromotographic (VMA)	11.00
108666	VDRL	5.00
108352	Vitamin B_{12}	12.00
108080	Vitamin C; ascorbic acid	6.00
108138	Vitamin M; folic acid (folate level)	10.00

Service Code	Service Description	Allowable Fee
108364	WBC; white cell count	$ 2.00
108881	Wet mount, any source, potassium hydroxide	3.00
108355	Xylose, tolerance test (blood)	8.00
108358	Xylose, urine	8.00
108878	Zinc	8.00
108356	Zinc, tolerance test, blood	8.00

(B) Profile Tests.

(1) "List A" Profiles. When one or two of the tests listed here are performed as individual (bench) tests, the CHC may bill according to the fee for the individual test (see Subsection 405.601(A)). However, when three or more of these tests are performed as a profile (as defined in Subsection 405.433(B)), the CHC must bill according to the rates below, except for an electrolyte profile (Service Code 108036), which may be billed as an "other profile". If one or more tests in the profile are not in the list below, but are in the fee schedule of individual tests (see Subsection 405.601(A)), the maximum allowable fee is the sum of the maximum allowable fee for the profile plus the maximum allowable fees for the individual tests listed in Subsection 405.601(A).

List A

(Note: The following profiles are frequently composed of tests in List A and should be billed for accordingly: cardiac profile, cerebral spinal fluid profile, hypertension screen, lipid profile, liver function profile, and renal profile.)

Albumin	Iron
Alkaline phosphatase	LDH
Bilirubin, total and direct	Phosphorus
BUN (urea nitrogen)	Potassium
Calcium	SGOT
Chloride	SGPT
Cholesterol	Sodium
CO_2	Total protein
Creatinine	Triglycerides
Globulin	Uric acid
Glucose	

Service Code	Service Description	Allowable Fee
108004	3 through 7 tests	$ 8.00
108008	8 through 12 tests	10.00
108013	13 through 17 tests	15.00
108018	18 tests and over	20.00

(2) Other Profiles. These profiles must be billed as a group, whether they are performed manually or automatedly (see Subsection 405.433(B)).

Service Code	Service Description	Allowable Fee
108026	Bone/joint Calcium Phosphorus RA latex screen Sedimentation rate Uric acid	$ 12.00
108361	Complete blood count (CBC) Hemoglobin Hematocrit White blood count Differential Red blood count	7.00
108036	Electrolytes Chlorides Potassium CO_2 Sodium	12.00
108042	Lipoprotein phenotyping Cholesterol Triglycerides Lipoprotein electrophoresis and phenotyping	20.00
108034	Premarital Serology Rubella	10.00
108027	Prenatal Blood group and Rh factor CBC Rubella antibody RPR Antibody screen	15.00
108046	Rheumatoid ASO titer C-reactive protein Antinuclear antibodies Latex fixation Uric acid	20.00

Service Code	Service Description	Allowable Fee
108048	Thyroid T_3-uptake T_4 Free thyroxine index	$ 12.00
108598	Radio allergy absorbent test (RAST) Cat epithelium Dog epithelium Egg white Giant ragweed Home dust Milk Penicillium notatum Timothy Yeast	70.00

405.602: Radiology Fee Schedule: Routine Services

Service Code	Service Description	Allowable Fee
	Head and Neck	
017008	Eye, determination of foreign body	$ 22.00
017009	Eye, localization of foreign body	37.00
017014	Mandible, unilateral, two views	17.00
017015	bilateral, more than two views	20.00
017020	Mastoids, less than four views	22.00
017021	minimum four views	37.00
017025	Facial bones, orbits, unilateral	22.00
017026	bilateral, minimum three views	33.50
017030	Nasal bones, three views minimum	17.00
017039	Optic foramina	17.00
017049	Paranasal sinuses, four views minimum	22.00
017054	Skull, paranasal sinuses, or sella turcica, single view	11.50
017059	Skull or sella turcica, two through four views	28.50
017060	Skull with stereo as indicated, minimum five views (complete study)	37.00
017070	Temporomandibular joints, open and closed, unilateral	20.00
017071	bilateral	28.50
017077	Neck, soft tissues examination	13.50
017080	Larynx and hypopharynx	17.00
017085	Salivary gland for calculus	17.00

Service Code	Service Description		Allowable Fee
	Chest		
017101	Chest, single view		$ 13.50
017102	P.A. and lateral view, two views		17.00
017103	multiple views, three or more		22.00
017150	Ribs, unilateral, minimum three views		28.50
017151	bilateral, minimum five views		28.50
017170	Sternum, two views minimum		17.00
017175	Sternoclavicular joints, three views minimum		17.00
	Spine and Pelvis		
017200	Spine, entire, survey study, A.P. and lateral, each area		45.00
017205	cervical, A.P. and lateral, two views		19.00
017210	thoracic, A.P. and lateral, two views		22.00
017211	thoraco-lumbar (lower thoracic, upper lumbar), two views		22.00
017212	lumbar, A.P. and lateral		22.00
017213	lumbosacral		22.00
017217	Scoliosis survey, fusion or leg length integrity		20.00
017220	Pelvis and hips or sacroiliac study, one view only		17.00
017221	One A.P. view of pelvis and both hips with any of the above spinal X rays	add	9.50
017222	Stereo, any part of the spine or pelvis, two views with any of the above spinal X rays	add	9.50
017223	Obliques, any part of the spine or pelvis, two views with any of the above spinal X rays	add	9.50

Service Code	Service Description		Allowable Fee
017225	Flexion and extension, any part of spine, two views with any of the above spinal X rays	add	$ 9.50
017226	Bending views, any part of spine, one projection, two views	add	9.50
017227	Pelvis or sacroiliac joints, minimum three views		22.00
	(For pelvimetry, see Service Code 017390.)		
017228	Sacrum and/or coccyx		17.00
	Upper Extremities		
017260	Acromioclavicular joints, clavicle, scapula, or shoulder, one view		13.50
017261	two views		14.50
017265	three or more views, with or without distraction		17.00
017270	Humerus, routine study		17.00
017276	Elbow, routine study		17.00
017280	Forearm, routine study		17.00
017286	Wrist, routine study		17.00
017290	Hand or fingers, routine study		17.00
017291	Hand and wrist, routine study		28.50
017292	Navicular views		17.00
017293	Comparison study of any of the above (017260-017292) at same sitting		9.50
	Lower Extremities		
017300	Hip, one view		13.50
017301	A.P. and lateral		17.00

Service Code	Service Description		Allowable Fee
017304	Hip and/or pelvis, routine study		$ 20.00
017308	Femur (thigh), including one joint		17.00
017309	shaft, A.P. and lateral		17.00
017310	Knee, routine study		17.00
017311	tunnel or subpatella study, routine study	add	9.50
017315	Tibia and fibula (lower leg), routine study		14.50
017316	Leg, including one joint		17.00
017319	Ankle, routine study		17.00
017323	Foot and/or toes, routine study, minimum three views		17.00
017324	Foot, including special os calcis views		25.00
017326	Os calcis (heel), routine study		17.00
017327	Foot and ankle, routine study		28.50
017328	Comparison study of any of the above (017300-017327) at same sitting		9.50
	Abdomen		
	All fees in this section include an allowance for a K.U.B. or flat plate of the abdomen.		
017330	Abdomen, single view (I.P.)		17.00
017331	multiple views (I.P.)		22.00

Service Code	Service Description	Allowable Fee
	Gastrointestinal Tract	
017348	Cholecystography, oral (if radiologist is not on site at time of test, procedure must include both supine position and either upright or lateral decubitus)	$ 28.50
	Urological	
	All fees in this section include an allowance for a K.U.B. or flat plate of the abdomen.	
017360	Abdomen (K.U.B.), single view (I.P.)	17.00
017361	multiple views (I.P.)	22.00
	Miscellaneous	
017554	Bone age studies	17.00
017555	Bone length studies	17.00
017557	Bone survey, long bones for metastasis	33.50
017559	Metastatic series, including chest	50.50

405.603: Radiology Fee Schedule: Services Requiring Presence of Radiologist

Service Code	Service Description	Allowable Fee
	Head and Neck	
017003	Echoencephalography	$ 22.00
017088	Sialogram, unilateral	17.00
017089	bilateral	22.00
	Chest	
017105	Chest, multiple views with fluoroscopy (complete chest)	28.50
017130	Bronchography, unilateral	28.50
017131	bilateral	45.00
	Abdomen	
	All fees in this section include an allowance for a K.U.B. or flat plate of the abdomen.	
017329	Ultrasound, abdomen (includes technical and professional component)	62.00
017333	Abdomen, special studies such as passage of Miller-Abbot tube, fluoroscopy only (no films) (I.P.)	22.00
017336	Ultrasound, abdomen, follow-up exam (includes technical and professional component)	31.50
	Gastrointestinal Tract	
017335	Esophagus and/or pharynx (I.P.)	22.00
017337	Upper gastrointestinal examination	39.00
017339	Upper gastrointestinal and small bowel examination	56.50

Service Code	Service Description	Allowable Fee
017341	Small bowel examination (separate study) with or without fluoro or K.U.B.	$ 28.50
017344	Colon examination, barium enema	39.00
017345	barium enema plus double contrast exam, same day	45.00
017346	double contrast examination as principal procedure	45.00
017351	Cholangiography, postoperative, through T-tube	28.50
017352	intravenous	39.00
017353	Upper G.I. double contrast exam	45.00
017354	Hypotonic duodenography (I.P.)	39.00
	Urological	
	All fees in this section include an allowance for a K.U.B. or flat plate of the abdomen.	
017363	Urography, intravenous, routine	39.00
017364	special hypertensive study	45.00
017366	Urography, drip infusion intravenous	56.50
017368	Cystography or incontinence study	22.00
017371	Urethrocystography, retrograde	33.50
017372	voiding	28.50
	Gynecological and Obstetrical	
	(For abdomen and pelvis, see Service Codes 017220 through 017227, 017330, and 017331.)	
017390	Pregnancy with pelvic measurements	28.50
017393	Hysterosalpingogram (utersalpinography)	39.00

Service Code	Service Description		Allowable Fee
017395	Seminography		$ 17.00
	Miscellaneous		
017524	Fluoroscopy only		11.50
017560	Arthrography		28.50
017561	Bone survey for lead poisoning		33.50
017563	Fistula or sinus tract study		17.00
017565	Mammography, unilateral		22.00
017566	bilateral		33.50
017567	Body section radiography, laminography (in addition to scheduled X-ray fee for part)	add	22.00

REGULATORY AUTHORITY

106 CMR 405.000: M.G.L. c. 18, s. 10; M.G.L. c. 118E, s. 4.

106 CMR is amended by repealing 106 CMR 466.000: Drugs, and adding the following chapter:

106 CMR 406.000: MEDICAL ASSISTANCE PROGRAM: PHARMACY SERVICES

Section

(106 CMR 406.001 through 406.400 Reserved)
406.401 Introduction
406.402 Definitions
406.403 Eligible Recipients
406.404 Provider Eligibility
406.405 Dispensing Pharmacists
406.406 Drugs and Medical Supplies Provided outside of Massachusetts
406.407 Prescription Requirements
406.408 Reimbursable Drugs and Medical Supplies
406.409 Service Limitations
406.410 Drug Restrictions for General Relief Recipients
406.411 Drugs and Medical Supplies for Institutionalized Recipients
406.412 Prior Authorization
(106 CMR 406.413 through 406.419 Reserved)
406.420 Payment Rates: Introduction
406.421 Payment Rates: Legend Drugs
406.422 Payment Rates: Nonlegend Drugs
406.423 Payment Rates: Dispensing Fees
406.424 Payment Rates: Medical Supplies
406.425 Disclosure of Information
(106 CMR 406.426 through 406.430 Reserved)
406.431 Medical Services Control Program
406.432 List of Direct-Price Drugs
406.433 List of Volume-Price Drugs

(106 CMR 406.001 through 406.400 Reserved)

406.401: Introduction

All pharmacies participating in the Medical Assistance Program must comply with the Department's regulations and with all federal and state laws and regulations governing the dispensing of drugs.

406.402: Definitions

The definitions in this section are based on regulations adopted by the Massachusetts Rate Setting Commission (114.3 CMR 31.00: Prescribed Drugs). In the event of conflict between these Department regulations and Rate Setting Commission regulations, Rate Setting Commission regulations shall govern.

(A) Adjusted Acquisition Cost -- the price paid to a supplier by a pharmacy for medical supplies after adjustment for quantity discounts and excluding all associated costs such as, but not limited to, shipping, handling, and insurance costs. The adjusted acquisition cost shall not exceed the price to the pharmacy as listed or determined in the manufacturer's current catalog and shall be evidenced by the purchase price for the supplies listed on a copy of the receipted invoice from the supplier.

(B) Average Wholesale Price -- the average (mean) unit price generally and currently charged for the standard package size of a drug by a representative group of wholesale drug distributors throughout the country to their retail customers (as listed in the Red Book), less a discount of five percent.

(C) Compounded Drug -- any drug, excluding cough preparations, in which two or more ingredients are extemporaneously mixed by a registered pharmacist.

(D) Controlled Substance -- a drug listed in Schedules II, III, IV, or V of the Massachusetts Controlled Substances Act (M.G.L. c. 94C).

(E) Direct Price -- the unit price charged for the most frequently purchased package size of selected drugs (listed in Section 406.432) by pharmaceutical manufacturers to their direct customers (as listed in the Red Book, or as recommended in the manufacturer's catalog if the drug is not listed in the Red Book).

(F) Dispensing Fee -- the fee paid, over and above the ingredient cost of the drug, to a pharmacy for dispensing a prescribed drug to a recipient.

(G) Drug -- a substance containing one or more active ingredients in a specified dosage form and strength. Each dosage form and strength is a separate drug.

(H) Drug Formulary Commission -- a nine-member panel, established pursuant to M.G.L. c. 17, s. 13, that is required to prepare a drug formulary of interchangeable drug products for adoption as a regulation by the Massachusetts Department of Public Health.

(I) Estimated Acquisition Cost -- an estimate of the price generally and currently paid by pharmacies for the most frequently purchased package size of a drug. This price shall be determined by the Rate Setting Commission and shall not exceed the lowest of the following:

(1) direct price;
(2) volume wholesale price;
(3) average wholesale price; or
(4) wholesale price.

(J) High-Ingredient-Cost Drug -- any drug for which the ingredient costs as determined under Rate Setting Commission regulations exceed $25.00.

(K) Interchangeable Drug Product -- a product containing a drug in the same amounts of the same active ingredients in the same dosage form as another product with the same generic or chemical name, as listed in the current edition of the Massachusetts List of Interchangeable Drugs or supplement thereof (105 CMR 720.000).

(L) Legend Drug -- any drug for which a prescription is required by applicable federal and state law or regulation.

(M) Manufacturer's Catalog -- the current edition, including supplements, of any pharmaceutical manufacturer's catalog.

(N) Massachusetts Maximum Allowable Cost (MMAC) -- the average (mean) unit price charged for the standard package size of a multiple-source drug by a representative group of Massachusetts wholesale drug distributors (or by out-of-state wholesalers if the drug is not widely available in Massachusetts) to their retail customers. The MMAC shall not apply to a multiple-source trade-name drug prescribed and dispensed to a recipient when the pharmacist is required by law or regulation to dispense the trade-name drug.

(O) Maximum Allowable Cost (MAC) -- the lowest unit price at which the most frequently purchased package size of a multiple-

source drug is widely and consistently available, as determined by the Pharmaceutical Reimbursement Board. The MAC shall apply solely to multiple-source drugs dispensed by a pharmacy to a recipient; however, it shall not apply to a multiple-source trade-name drug if the prescriber has designated on the prescription form that the drug is medically necessary for that recipient.

(P) Medical Supplies -- medical/treatment products that:
(1) are fabricated primarily and customarily to fulfill a medical purpose;
(2) are used in the treatment of a specific medical condition; and
(3) are nonreusable and disposable.

(Q) Most Frequently Purchased Package Size -- the package size of a drug most frequently purchased by pharmacies.

(R) Multiple-Source Drug -- a drug marketed or sold by two or more manufacturers or labelers, or a drug marketed or sold by the same manufacturer or labeler under two or more different names.

(S) Multiple-Source Generic Drug -- a multiple-source drug marketed under a nonproprietary chemical name and included within the drug formulary of interchangeable drug products prepared by the Drug Formulary Commission.

(T) Multiple-Source Trade-Name Drug -- a multiple-source drug marketed under a manufacturer's trade name.

(U) Nonlegend Drug -- any drug for which no prescription is required by federal or state law.

(V) Pharmaceutical Reimbursement Board -- a five-member panel, established pursuant to 45 CFR Subtitle A, Part 19, that determines the maximum allowable cost for selected multiple-source drugs. The Board is required to maintain and make publicly available a list of maximum allowable cost determinations and to renew the list regularly to ensure that continued application of each maximum allowable cost is justified.

(W) Red Book -- the current edition, including quarterly supplements, of the Drug Topics Red Book.

(X) Single-Source Drug -- a drug marketed or sold by one manufacturer or labeler under one proprietary name.

(Y) Standard Package Size -- the package size of any drug for which a most frequently purchased package size has not been determined by the Rate Setting Commission, which shall be as follows:

(1) tablets and capsules 100s;
(2) liquids ..... 480 ml.;
(3) ampuls and suppositories ..... 10s; and
(4) vials ..... 10 ml.

If the quantities above are not commercially available, the standard package size means that commercially available size equal to or next largest to the quantity dispensed.

(Z) Usual and Customary Charge -- the price charged for a given volume of drugs (legend or nonlegend) on a given day by a pharmacy to its retail customers (institutional purchasers as well as over-the-counter purchasers). If a drug is on sale for a one-week period, the usual and customary charge for that drug during that week is the sale price. If the price of a drug is discounted to retail customers when purchased in volume, the usual and customary charge for that volume of that drug is the discounted price. Examples are given below.

(1) A pharmacy's usual charge for a quantity of 30 Valium tablets is $3.30. During the week of November 26, 1979 through December 1, 1979, the drug is specially priced at $3.00 for a quantity of 30. The usual and customary charge during that week is $3.00 for a quantity of 30.

(2) A pharmacy's usual charge for a quantity of 30 Donnatal capsules is $2.90. This pharmacy offers a ten-percent discount to all persons aged 65 or older. A 68-year-old recipient purchases a quantity of 30 Donnatal capsules. The usual and customary charge for this person is $2.61 ($2.90 less ten percent).

(3) A pharmacy's usual charge for a quantity of 30 250 mg. tablets of penicillin VK is $2.80. For persons using any of several charge payment systems offered by the pharmacy, a five-percent surcharge is added to cover administrative costs. The usual and customary charge for a quantity of 30 250 mg. tablets of penicillin VK is $2.80. Additional charges for administrative services are not permitted.

(AA) Volume Wholesale Price -- the unit price (average wholesale price or wholesale price) generally and currently charged for the most frequently purchased package size of selected drugs listed in Section 406.433 by wholesale drug distributors to their retail customers (as listed in the Red Book, or as recommended in the manufacturer's catalog if the drug is not listed in the Red Book), less a discount of five percent.

(BB) Wholesale Price -- the unit price generally and currently charged for the standard package size of a drug by wholesale drug distributors to their retail customers (as listed in the Red Book, or as recommended in the manufacturer's catalog if the drug is not listed in the Red Book), less a discount of five percent.

406.403: Eligible Recipients

(A) Medical Assistance Recipients. The Department pays for drugs and medical supplies provided to Medical Assistance recipients (categories of assistance 00, 01, 02, 03, 05, 06, 07, and 08) subject to the restrictions and limitations in these regulations.

(B) General Relief Recipients. For General Relief recipients (category of assistance 04), the Department pays only for life-sustaining drugs in the therapeutic classes listed in Section 406.410 and for medical supplies.

406.404: Provider Eligibility

(A) A pharmacy must be a participant in the Medical Assistance Program on the date of service in order to be eligible for payment.

(B) A pharmacy must be assigned a Controlled Substances number by the federal Drug Enforcement Administration.

(C) A Massachusetts pharmacy must be licensed by the Massachusetts Board of Registration in Pharmacy. An out-of-state pharmacy must be licensed in its own state.

(D) An out-of-state pharmacy must participate in its own state's Medical Assistance Program (or equivalent).

406.405: Dispensing Pharmacists

A Massachusetts pharmacist must be licensed by the Massachusetts Board of Registration in Pharmacy. An out-of-state pharmacist must be licensed in his own state.

406.406: Drugs and Medical Supplies Provided outside of Massachusetts

When provided out of state, drugs and medical supplies are reimbursable only under the following circumstances:

(A) the recipient is temporarily out of state and requires drugs or medical supplies on an emergency basis; or

(B) the recipient lives in an area of Massachusetts that borders on another state, and drugs or medical supplies are more readily available in the adjacent state.

406.407: Prescription Requirements

(A) Written Prescription Requirements. Except as provided in Subsection (B) below, legend drugs, nonlegend drugs, and medical supplies are reimbursable only after the pharmacy has obtained a written prescription signed by an authorized prescriber. All prescriptions for drugs written by prescribers in Massachusetts must be written on a prescription form approved by the Massachusetts Department of Public Health (Generic Drug Law, M.G.L. c. 112, s. 12D). The prescription must contain the following information:

(1) the recipient's name and address;
(2) the drug name, strength, dosage schedule, and quantity, or the name and quantity of the medical supply;
(3) the number of authorized refills;
(4) the prescriber's name, address, and, when required, Drug Enforcement Administration (DEA) number;
(5) the prescriber's signature (preprinted or rubber-stamped signatures are invalid); and
(6) the date on which the prescription was signed by the prescriber.

(B) Waiver of Written Prescription Requirement. Subsection (A) above notwithstanding, an oral/telephone prescription order as defined in M.G.L. c. 94C, s. 20(c) and containing the information listed in Subsections (A)(1) through (A)(4) above, is recognized as a valid prescription only in the following cases.

(1) The drug prescribed is listed in Schedule VI of the Massachusetts Controlled Substances Act.
(2) For a recipient in a nursing home or rest home: the drug prescribed is listed in Schedules III, IV, V, or VI of the Massachusetts Controlled Substances Act.
(3) The prescriber states that an emergency exists. In an emergency, the drug must be dispensed in compliance with state and federal regulations and in accordance with the following requirements:

(a) the drug quantity may not exceed a 72-hour supply; and

(b) the prescription may not be refilled.

The prescriber must give an original written prescription that conforms with Subsection (A) above to the pharmacy within 72 hours after the oral/telephone order for a drug listed in Schedule II of the Massachusetts Controlled Substances Act, or within seven days after the oral/telephone order for a drug listed in Schedules III, IV, or V of the Massachusetts Controlled Substances Act.

(C) Refills. A prescription may be refilled for the number of times authorized by the prescriber, to a maximum of five refills. No refill may be dispensed after six months from the date of the original prescription. The absence of an indication to refill by the prescriber renders the prescription nonrefillable.

406.408: Reimbursable Drugs and Medical Supplies

(A) Legend Drugs. The Department will pay for legend drugs except as outlined in Section 406.409. Payment is calculated in accordance with Section 406.421. The "List of Commonly Prescribed Legend Drugs" in the Drug and Medical Supply List is provided as a reference to assist in billing.

(B) Nonlegend Drugs. The Department will pay for the nonlegend drugs included in the "List of Nonlegend Drugs" in the Drug and Medical Supply List. Payment is calculated in accordance with Section 406.422. Nonlegend drugs not included in the Drug and Medical Supply List require prior authorization (see Section 406.412).

(C) Medical Supplies. The Department will pay for medical supplies included in the "List of Medical Supplies" in the Drug and Medical Supply List that are priced at or below $35.00. Payment is calculated in accordance with Section 406.424. Medical supplies not included in the Drug and Medical Supply List or priced above $35.00 require prior authorization (see Section 406.412).

406.409: Service Limitations

The Department will pay for legend drugs except as outlined below. The Department will pay for the nonlegend drugs listed in the Drug and Medical Supply List.

(A) Methyl Phenidate (Ritalin) and Amphetamines. The Department does not pay for methyl phenidate (Ritalin), amphetamines (including amphetamines in combination), or any other drugs when they are used for control of the appetite. When prescribed for the treatment of hyperkinesis, however, such drugs are reimbursable without prior authorization if the prescriber writes on the prescription the words "for hyperkinesis" and if the recipient is under 17 years of age. All other uses of amphetamines require prior authorization (see Section 406.412).

(B) Vitamins. The Department pays for vitamins included in the Drug and Medical Supply List only when they are dispensed to infants or children through the age of 36 months or to pregnant women. Plain fluorides are reimbursable when they are dispensed to recipients up to the age of 12 years. General multiple vitamins NF (National Formulary) in a unit of 100 are reimbursable without age restriction.

(C) Iron. The Department pays for only those iron preparations included in the Drug and Medical Supply List.

(D) Immunizing Biologicals and Tubercular Drugs.

(1) Immunizing biologicals and tubercular (TB) drugs available free of charge through local boards of public health or through the Massachusetts Department of Public Health are not reimbursable. If the recipient has a prescription, however, the Department will pay for the following drugs for a nonambulatory recipient who cannot attend one of the Department of Public Health clinics: Isoniazid, Myambutal, and P.A.S. All other such drugs require prior authorization (see Section 406.412).

(2) Subsection (D)(1) above notwithstanding, the Department does pay for pneumococcal vaccine when dispensed to a noninstitutionalized recipient.

(E) Antacids. The Department pays for antacids only when dispensed to a noninstitutionalized recipient and only if the recipient has gastritis, hiatus hernia, or ulcers.

(F) Laxatives and Stool Softeners. The Department does not pay for laxatives or stool softeners.

(G) Cough and Cold Preparations. The Department does not pay for legend or nonlegend preparations that contain a decongestant, antitussive, or expectorant as a major ingredient when they are dispensed to a noninstitutionalized recipient.

(H) Propoxyphene. The Department does not pay for any drug product that contains propoxyphene, with the following two exceptions:

(1) propoxyphene hydrochloride 32 mg.; and
(2) propoxyphene hydrochloride 65 mg.

(I) Hexachlorophene Preparations. The Department does not pay for preparations containing hexachlorophene, U.S.P. as the major active ingredient.

(J) Less-Than-Effective Drugs. The Department does not pay for drug products (including identical, similar, or related drug products) that the U.S. Food and Drug Administration has proposed, in a notice of opportunity for hearing (NOOH), to withdraw from the market because they lack substantial evidence of effectiveness for all labeled indications. (Examples of drug products affected by this regulation are listed in Appendix E of the Pharmacy Manual.)

406.410: Drug Restrictions for General Relief Recipients

(A) For General Relief recipients (category of assistance 04), as required by the General Laws of Massachusetts, only life-sustaining drugs are reimbursable. The Department pays for life-sustaining drugs in the following therapeutic classes for General Relief recipients:

CA--Antineoplastic Agents
OP--Ophthalmic Preparations
04--Antispasmo Anticholinerg
07--Major Tranquilizers
08--Oral Muscle Relaxants
11--Psychostimulants
15--Bronchial Dilators
21--Broad Spectrum Antibiotics
22--Penicillin
24--Sulfonamides
25--Antibiotics Sulfa
27--Other Nonsystemic Antibiotics
28--Urinary Antibacterial Analgesics
31--Amebicides Trichomonas
32--Antimalarials
33--Anthelmintics
34--TB Preparations
39--Antialcoholic
48--Anticonvulsant (including Phenobarbital, Luminal, and Mebaral)
51--Corticoids, Plain and Injectable
55--Thyroid Preparations
56--Antithyroid Preparations
58--Diabetic Therapy
70--Rauwolfias
71--Other Hypotensives
72--Vasodilators Coronary
74--Digitalis Preparations
75--Xanthine Derivatives
76--Other Cardiovascular Preparations
77--Anticoagulants
78--Hemostatics
79--Diuretics
87--Electrolytes and Miscellaneous Nutriments

(B) For General Relief recipients, any drug that is not a life-sustaining drug in a therapeutic class listed in Sub-

section (A) above requires prior authorization (see Section 406.412).

406.411: Drugs and Medical Supplies for Institutionalized Recipients

(A) The Department does not pay for nonlegend drugs or medical supplies provided to an institutionalized recipient.

(B) The Department pays for legend drugs and ostomy supplies provided to an institutionalized recipient.

406.412: Prior Authorization

(A) If the limitations on payment specified in Sections 406.408 through 406.410 would result in inadequate treatment for a diagnosed medical condition, the prescriber may submit a written request to the Department for prior authorization for an otherwise nonreimbursable drug or medical supply. The Department will consider a prior authorization request on behalf of a General Relief recipient for only those drugs used to treat a medical condition that may result in long-term functional impairment or immediate pain and suffering if left untreated.

(B) All prior authorization requests must be submitted in accordance with the instructions in Subchapter 5 of the Pharmacy Manual. If the Department approves the request, it will notify the prescriber and assign a prior authorization number that must be written on the prescription. When claiming payment, the pharmacy must enter the prior authorization number on the claim form.

(C) Prior authorization does not waive any other prerequisites to payment such as, but not limited to, recipient eligibility or resort to health insurance payment.

(106 CMR 406.413 through 406.419 Reserved)

406.420: Payment Rates: Introduction

The methods for determining payment contained in Sections 406.421 through 406.423 are based on regulations adopted by the Massachusetts Rate Setting Commission (114.3 CMR 31.00: Prescribed Drugs). In the event of conflict between these Department regulations and Rate Setting Commission regulations, Rate Setting Commission regulations shall govern.

406.421: Payment Rates: Legend Drugs

(A) Payment Rate for Single-Source Drugs.

(1) Except as stated in Subsection (A)(2) below, payment to a pharmacy for a single-source legend drug dispensed to a recipient shall not exceed the lower of:

(a) the estimated acquisition cost of the drug, plus the appropriate dispensing fee (see Section 406.423); or

(b) the usual and customary charge to the pharmacy's retail customers for the drug.

(2) In the case of controlled substances, payment shall not exceed the lower of:

(a) the estimated acquisition cost of the drug, plus a surcharge of up to ten percent determined by the Department, plus the appropriate dispensing fee (see Section 406.423); or

(b) the usual and customary charge to the pharmacy's retail customers for the drug.

(B) Payment Rate for Multiple-Source Trade-Name Drugs.

(1) Except as stated in Subsection (D) below, payment to a pharmacy for a multiple-source trade-name legend drug dispensed to a recipient shall not exceed the lowest of:

(a) the maximum allowable cost of the drug, if any, plus the appropriate dispensing fee (see Section 406.423), provided that the prescriber has not designated the drug as medically necessary on the prescription form;

(b) the estimated acquisition cost of the drug, plus the appropriate dispensing fee;

(c) the usual and customary charge to the pharmacy's retail customers for the drug; or

(d) the Massachusetts maximum allowable cost of the drug, plus the appropriate dispensing fee.

(2) Limitation to the cost in Subsection (B)(1)(a) above shall not apply when a prescriber certifies in his own handwriting on the face of the prescription that, in his medical judgment, a specific brand of medication is medically necessary for a particular recipient. An acceptable certification written on the face of the prescription is "brand medically necessary" or "dispense as written". A procedure for checking off a box or signing on a line designated "dispense as written" does not constitute an acceptable certification. In determining payment for oral/telephone prescriptions, cost shall be limited to an amount no greater than the maximum established above, unless the pharmacy possesses such a certified prescription.

(C) Payment Rate for Multiple-Source Generic Drugs. Except as stated in Subsection (D) below, payment to a pharmacy for a

multiple-source generic legend drug dispensed to a recipient shall not exceed the lowest of:

(1) the maximum allowable cost of the drug, if any, plus the appropriate dispensing fee (see Section 406.423);

(2) the Massachusetts maximum allowable cost of the drug, plus the appropriate dispensing fee; or

(3) the usual and customary charge to the pharmacy's retail customers for the drug.

(D) Payment Rate for Multiple-Source Controlled Substances. In the case of controlled substances (multiple-source trade-name drugs and multiple-source generic drugs), payment shall not exceed the lowest of:

(1) the maximum allowable cost of the drug, if any, plus the appropriate dispensing fee (see Section 406.423), provided that the prescriber has not designated the drug as "medically necessary" on the prescription form;

(2) the estimated acquisition cost of the drug, plus a surcharge of up to ten percent determined by the Department, plus the appropriate dispensing fee (see Section 406.423);

(3) the usual and customary charge to the pharmacy's retail customers for the drug; or

(4) the Massachusetts maximum allowable cost of the drug, plus the appropriate dispensing fee.

(E) Payment Rate for Interchangeable Drug Products. In no case where the signature of the prescriber appears on the "interchange" line of the prescription form shall payment exceed the rate of payment for a less-expensive, reasonably available interchangeable drug product as listed in the most recent edition of the Massachusetts List of Interchangeable Drugs or supplement thereof.

406.422: Payment Rates: Nonlegend Drugs

Payment to a pharmacy for a nonlegend drug dispensed to a recipient shall not exceed the lower of:

(A) the estimated acquisition cost of the drug, plus the appropriate dispensing fee (see Section 406.423); or

(B) the usual and customary charge to the pharmacy's retail customers for the drug.

406.423: Payment Rates: Dispensing Fees

The dispensing fee shall be $2.90 except as specified below.

(A) Compounded Drugs.
(1) The dispensing fee shall be $3.90 for compounding ointments or solutions or for preparing solutions (excluding cough preparations) that involve the weighing of ingredients.
(2) The dispensing fee shall be $4.90 for compounding suppositories, capsules, tablets, triturates, or powders.

(B) High-Ingredient-Cost Drugs. The dispensing fee shall be $2.90 for a high-ingredient-cost drug, unless the pharmacy obtains prior authorization from the Department for a higher dispensing fee. (See the prior authorization instructions in Subchapter 5 of the Pharmacy Manual.)

406.424: Payment Rates: Medical Supplies

The methods for determining payment for medical supplies contained in this section are based on regulations adopted by the Massachusetts Rate Setting Commission (114.3 CMR 22.00: Durable Medical Equipment and Orthotic Devices). In the event of conflict between these Department regulations and Rate Setting Commission regulations, Rate Setting Commission regulations shall govern. Payment to a pharmacy for medical supplies provided to a recipient shall not exceed the lower of:

(A) the adjusted acquisition cost, plus a markup not to exceed:
(1) 50 percent for any item whose adjusted acquisition cost is less than $25.00;
(2) 45 percent for any item whose adjusted acquisition cost is $25.00 or greater and less than $100.00;
(3) 40 percent for any item whose adjusted acquisition cost is $100.00 or greater and less than $200.00;
(4) 35 percent for any item whose adjusted acquisition cost is $200.00 or greater and less than $300.00; or
(5) 30 percent for any item whose adjusted acquisition cost is $300.00 or greater; or

(B) the usual and customary charge to the pharmacy's retail customers for the supply.

406.425: Disclosure of Information

In order for the Department to verify a pharmacy's compliance with Sections 406.421 and 406.422, a pharmacy must, upon request, make available to the Department for inspection and copying the following documentation:

(A) all prescriptions (for both recipients and nonrecipients) filled during the time period specified by the Department. The name of the patient and all other identifying information shall be blocked out; or

(B) all price lists that were in effect for such time period.

(106 CMR 406.426 through 406.430 Reserved)

406.431: Medical Services Control Program

(A) Introduction. The Department's Medical Services Control Program is established to prevent Medical Assistance recipients from obtaining excessive quantities of prescribed drugs through multiple visits to physicians and pharmacies. Recipients who are enrolled in the Program are issued an Eligibility Card that indicates that they may obtain medications from only one pharmacy, referred to as the "primary pharmacy". This primary pharmacy is responsible for monitoring the recipient's drug utilization.

(B) Enrollment of Recipients.

(1) The Department selects for enrollment in the Medical Services Control Program recipients who have a documented history of obtaining excessive or inappropriate prescribed drugs under the Medical Assistance Program. Recipients are notified of this action ten days prior to the implementation of the restriction and are requested to choose a primary pharmacy as the single source for all prescribed drugs.

(2) If the recipient fails to choose a primary pharmacy, the Department shall select the primary pharmacy based on the recipient's previous pharmacy use and geographical location.

(3) The Department notifies the primary pharmacy of the identity of recipients restricted to that pharmacy.

(C) Restrictive Eligibility Card.

(1) Recipients enrolled in the Medical Services Control Program are issued a Medicaid Eligibility Card containing the message: MEDICATION CONTROL. RECIPIENT RESTRICTED TO PRIMARY PHARMACY. The restriction applies to all recip-

ients whose names are listed on the card.

(2) Except as outlined in Subsection (C)(3) below, no pharmacy except the recipient's primary pharmacy may receive payment from the Department for drugs dispensed to a recipient whose Medicaid Eligibility Card bears the restriction message.

(3) In an emergency verified by an authorized prescriber, a pharmacy other than the primary pharmacy may dispense a maximum of a 72-hour supply of a drug to a restricted recipient only if that drug is listed in Schedule VI of the Massachusetts Controlled Substances Act (M.G.L. c. 94C). The pharmacy must obtain an original prescription from the prescriber stating that an emergency exists.

(D) Responsibilities of Primary Pharmacy. The primary pharmacy must monitor the drug utilization of each restricted recipient and must exercise sound professional judgment when dispensing drugs in order to prevent inappropriate drug utilization by the recipient. When the pharmacist reasonably believes that the recipient is attempting to obtain excessive drugs through duplicate prescriptions or other inappropriate means, the pharmacist must contact the prescribing physician to verify the authenticity and accuracy of the prescription presented. Primary pharmacies that are found on review to be dispensing drugs in a manner that is inconsistent with professional standards may be subject to administrative action by the Department, including the recovery of payments and the imposition of sanctions.

(E) Change in Primary Pharmacy and Recipient Status.

(1) A recipient may change primary pharmacies for reasonable cause by notifying the Medical Services Control Program and choosing a new primary pharmacy.

(2) If, after review of the recipient's drug-usage profile, it is determined by the Medical Services Control Program that restriction of the recipient to the primary pharmacy is no longer appropriate, the restriction will be removed. Such review shall not take place prior to six months nor later than nine months from the date of enrollment.

406.432: List of Direct-Price Drugs

Drug Product and Strength	Size
Aldomet 250 mg.	1000
Aldomet 500 mg.	100
Aldoril 15 mg.	100
Aldoril 25 mg.	100
Atromid-S 500 mg.	100
Benadryl capsules 25 mg.	100
Benadryl kapseals 50 mg.	1000
Cogentin 2 mg.	100
Diabinese 250 mg.	1000
Diamox 250 mg.	100
Dilantin kapseals 100 mg.	1000
Diuril 250 mg.	100
Diuril 500 mg.	1000
Diupres 250 mg.	100
Diupres 500 mg.	100
Elavil 10 mg.	100
Elavil 25 mg.	100
Elavil 50 mg.	100
E-Mycin 250 mg.	100
Equagesic	50
Equanil 400 mg.	100
Erythocin 250 mg.	100
Hydrodiuril 25 mg.	100
Hydrodiuril 50 mg.	1000
Inderal 10 mg.	1000
Inderal 40 mg.	1000
Indocin 25 mg.	1000
Indocin 50 mg.	100
Motrin 400 mg.	500
Mycolog cream 15 mg.	--
Mycolog cream 30 mg.	--
Noctec 500 mg.	100
Orinase 0.5 gm.	1000
Ovral-21 (based on pkg. size)	--
Pronestyl 250 mg.	100
Pronestyl 500 mg.	100
Sinequan 25 mg.	100
Tolinase 250 mg.	100
Tranxene 7.5 mg.	500
Triavil 2-10	100
Triavil 2-25	100
Triavil 4-25	100

406.433: List of Volume-Price Drugs

Drug Product and Strength	Size
Aldactazide	500
Aldactone 25 mg.	500
Dalmane 15 mg.	500
Dalmane 30 mg.	500
Dimetapp elixir	Gal.
Donnatal tabs.	1000
Dyazide caps.	1000
Elixophillin elixir	Gal.
Fiorinal tabs.	1000
Gantrisin	1000
Lanoxin 0.125 mg.	1000
Lanoxin 0.250 mg.	1000
Lasix 40 mg.	500
Librax caps.	500
Librium 5 mg.	500
Librium 10 mg.	500
Librium 25 mg.	500
Lomotil 2.5 mg.	500
Percodan	1000
Valium 2 mg.	500
Valium 5 mg.	500
Valium 10 mg.	500
V-Cillin K 250 mg.	500

106 CMR is amended by repealing 106 CMR 480.000: Medical Assistance Program: Project Good Health, and adding the following chapter:

106 CMR 418.000: MEDICAL ASSISTANCE PROGRAM: PROJECT GOOD HEALTH SERVICES

Section

(106 CMR 418.001 through 418.400 Reserved)
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418.402 Definitions
418.403 Eligible Recipients
418.404 Contracted Provider Eligibility
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418.451 Project Good Health Medical Periodicity Schedule
418.452 Project Good Health Dental Periodicity Schedule

(106 CMR 418.001 through 418.400 Reserved)

418.401: Introduction

(A) Legal Basis. Federal law governing Medical Assistance Programs requires the establishment of a program of Early and Periodic Screening, Diagnosis and Treatment (EPSDT) for persons under the age of 21 who are eligible for Medical Assistance (see 42 U.S.C. 1396d(a)(4)(b) and 42 CFR 441.50). "Project Good Health" (PGH) is the name given to the EPSDT program established in the Massachusetts Medical Assistance Program. This Chapter 418.000, which governs the administration of the PGH Program, includes regulations establishing the duties and functions of contracted providers.

(B) Program Objectives. The objectives of the PGH Program are:
(1) to provide to eligible persons comprehensive and continuous health care designed to prevent illness and disability, and to establish an on-going provider-patient relationship;
(2) to ensure early detection and prompt treatment of health problems before they become chronic or cause irreversible damage; and
(3) to create an awareness of the availability and value of preventive health-care services and to encourage maximum participation in the PGH Program.

418.402: Definitions

The following definitions apply when used in these regulations. Words set in SOLID CAPITALS are defined elsewhere in this list.

(A) Consultant -- a provider to whom a REFERRAL for additional screens or for treatment is made by a PGH PROVIDER.

(B) Contracted Provider -- a PGH PROVIDER with whom the Department has entered into a PGH provider agreement pursuant to Section 418.405.

(C) Health Assessment -- the performance for a PGH recipient of the screening package appropriate to his age, status, and history, as indicated by the MEDICAL PERIODICITY SCHEDULE.

(D) Medical Periodicity Schedule -- this schedule was developed by the Massachusetts Chapter of the American Academy of Pediatrics, and is reproduced as Section 418.451.

(E) PGH Program -- the Project Good Health Program, which is described in this Chapter 418.000 (see Section 418.401).

(F) PGH Provider -- a provider enrolled as a PGH provider pursuant to this Chapter 418.000, including CONTRACTED PROVIDERS and providers with whom alternative arrangements have been made pursuant to Section 418.406.

(G) PGH Specialist -- an employee of the Department assigned specifically to the PGH PROGRAM, whose principal function is to ensure the timely delivery of PGH services to PGH recipients.

(H) Referral -- a direction by a PGH PROVIDER to a PGH recipient to present himself in person to another provider for any test, examination, diagnosis, treatment, or other procedure that the referring PGH PROVIDER is unable to perform himself. The transmission of a specimen to a laboratory or other provider is not considered to be a referral.

418.403: Eligible Recipients

(A) Medical Assistance Recipients. The Department pays for PGH services provided to Medical Assistance recipients (categories of assistance 00, 02, 03, 06, 07, and 08) who have not yet attained the age of 21. The Department also pays for PGH services provided to Medical Assistance recipients who are parents who have not yet attained the age of 21.

(B) General Relief Recipients. The Department does not pay for PGH services provided to General Relief recipients (category of assistance 04).

106 CMR 405.000: MEDICAL ASSISTANCE PROGRAM: COMMUNITY HEALTH CENTER SERVICES

106 CMR 405.000 is amended by striking out all of the sections contained therein and inserting in their place the following sections:

Section

(106 CMR 405.001 through 405.400 Reserved)
405.401 Eligible Recipients
405.402 Provider Eligibility
405.403 Certification
405.404 Administrative Requirements
405.405 Physician Time Required on Site
405.406 Medical Services Required on Site
405.407 Medical Services Required on Site or by Referral
405.408 Continuity of Care and Case Management
405.409 Recordkeeping Requirements
405.410 Coordination of Services
405.411 Translation Services
405.412 Medical/Emergency Backup Services
405.413 Quality-Assessment Program
405.414 Maximum Allowable Fees
(106 CMR 405.415 through 405.420 Reserved)
405.421 Visits: Definitions
405.422 Visits: Fee Schedule
405.423 Deliveries: Definition
405.424 Deliveries: Fee Schedule
(106 CMR 405.425 through 405.430 Reserved)
405.431 Laboratory Services: Request-for-Services Requirement
405.432 Laboratory Services: Eligibility to Provide Services
405.433 Laboratory Services: Fee Schedule Explanation
405.434 Laboratory Services: Services Performed by Outside Laboratories
(106 CMR 405.435 through 405.440 Reserved)
405.441 Radiology Services: Request-for-Services Requirement
405.442 Radiology Services: Eligibility to Provide Services
405.443 Radiology Services: Fee Schedule Explanation
(106 CMR 405.444 through 405.450 Reserved)
405.451 Electrocardiogram (EKG) Services: Request-for-Services Requirement
405.452 Electrocardiogram (EKG) Services: Eligibility to Provide Services
405.453 Electrocardiogram (EKG) Services: Fee Schedule Explanation
405.454 Electrocardiogram (EKG) Services: Fee Schedule
(106 CMR 405.455 through 405.460 Reserved)
405.461 Audiology Services: Request-for-Services Requirement
405.462 Audiology Services: Eligibility to Provide Services
405.463 Audiology Services: Fee Schedule Explanation

418.404: Contracted Provider Eligibility

Prospective contracted providers include physicians, clinics, community health centers, hospital outpatient departments, health maintenance organizations, grantees under Title V of the Social Security Act (such as Children and Youth Projects and as Maternal and Infant Care Programs), and public or private youth-service agencies. In order to qualify as a contracted provider, a person, agency, or facility must meet the following standards.

(A) The provider must be able to furnish directly (i.e., in its own facility without referrals) substantially all of the health-assessment procedures referred to in Subsection 418.408(A), other than laboratory services.

(B) The provider must be able to provide by referral all of the health-assessment procedures referred to in Subsection 418.408(A) that it does not provide directly.

(C) The provider must be able to provide directly diagnostic and treatment services consistent with contemporary standards for the general practice of medicine, including referral linkages for laboratory procedures, vision and dental care, and specialty practice.

(D) The provider must be able to perform the duties described in Section 418.409.

(E) The provider must not be an agency or organization that customarily furnishes services without charge, or that restricts its services to persons eligible for Medical Assistance.

(F) The provider must be organized in a manner that permits billing by a single person or entity in accordance with Section 418.421.

(G) The provider and each employee or agent of the provider must be in compliance with every applicable statutory prerequisite relating to the services provided by such provider, employee, or agent, and to the facility in which such services are provided.

418.405: Provider Agreements

Applicants for enrollment as contracted providers are required to complete a PGH provider questionnaire, designed to reveal whether the resources in staff, facilities, referral linkages, and time that they can commit to PGH meet the eligibility standards set forth in Section 418.404. Applicants determined by the Department to meet those standards will, upon the signing of the Department's PGH provider agreement, be enrolled as PGH providers as of the effective date of the agreement.

418.406: Noncontracted Provider

Nothing in this Chapter 418.000 shall operate to prevent any provider who participates in the Medical Assistance Program in a provider type other than contracted PGH provider from continuing to provide services in that capacity to recipients eligible for PGH services. However, the procedure codes listed in Section 418.421 shall be used only by contracted providers.

418.407: Alternative Provider

If the number of contracted providers in any area of the Commonwealth of Massachusetts is insufficient to ensure the delivery of PGH services by contracted or noncontracted providers to all eligible recipients who want them, the Department shall make alternative arrangements in such areas with persons, agencies, and facilities that are ineligible to qualify as contracted providers, but that meet the standards set forth in Subsections 418.404(A), (B), (D), (F), and (G). The Department will make such alternative arrangements on an individual case-by-case basis, applying such other criteria as may be necessary to achieve the objectives of the PGH Program.

418.408: Services by Contracted Provider

A contracted provider that undertakes the care of a recipient eligible for PGH services must provide the following services.

(A) Medical Periodicity Schedule. The Department has adopted the Medical Periodicity Schedule set forth in Section 418.451. The Medical Periodicity Schedule was developed by the Massachusetts Chapter of the American Academy of Pediatrics, in cooperation with the Department, and consists of a series of simple preventive and screening procedures, arranged in "screening packages" according to the intervals or age levels at which each procedure is to be carried out. The Medical Periodicity Schedule is designed to provide basic preventive care, and to distinguish well patients from those who require further diagnosis of suspected or actual health problems, or treatment, or both. At the initial visit, and thereafter at the intervals dictated by the schedule, the PGH provider must provide a health assessment (i.e., the entire screening package appropriate to the recipient in accordance with the schedule). A provider must not omit any procedure in a health assessment except in the rare situation where the omission is authorized for lack of medical necessity or impossibility as set forth in Subsection 418.409(A). In the absence of such a reason, a provider who omits any procedure in a health assessment may not bill for, or certify the delivery of, a completed health assessment. (See Subsection 418.421(B) for billing procedures relative to partial health assessments.)

(B) Minimal Screening Requirements. Initial and interval health histories must include an assessment for mental and emotional problems.

The physical examination must include an assessment of growth, development, and nutritional status, and an examination for vision and hearing problems, anemia, sickle cell trait, lead poisoning, tuberculosis, diabetes, urinary abnormalities, and obvious physical defects. The items listed above constitute the minimum screens that must be performed directly by the PGH provider. (Hearing tests requiring the use of an audiometer, further diagnosis and treatment of vision and dental problems, and further laboratory tests may be referred to other providers.) In all cases, every screening, diagnostic, and treatment service must be performed by a person authorized by law to perform such a service.

(C) Continuing Comprehensive Care. PGH providers must furnish continuing comprehensive primary medical care, including preventive services and treatment indicated by any health assessment. The Department encourages single-source comprehensive primary care, in order to minimize the number of instances in which referrals must be made, records transferred, and relationships between providers and PGH recipients interrupted. However, a PGH provider must make referrals consistent with sound medical practice whenever a PGH recipient requires different or more extensive diagnosis or treatment than the PGH provider can adequately and competently provide.

(D) Referrals.

(1) Whenever a health assessment, a need for additional screens, or any other event prompts a PGH provider to make a referral, the PGH provider must make a reasonable effort to select an appropriate consultant and to arrange for an appointment at a date, time, and place mutually satisfactory to the recipient and the consultant. When appropriate, referrals may be made to such grantees under Title V of the Social Security Act as Children and Youth Projects and as Maternal and Infant Care Programs. If the PGH provider is unable to select a consultant or to arrange an appointment, the PGH provider must request the assistance of the Department's PGH specialist. The PGH provider must accomplish the tasks described in this subsection without delay and in any event in sufficient time to give reasonable assurance that the recipient will have an appointment with the consultant within 60 days after the event that prompted the referral.

(2) Whenever a PGH provider makes a referral, he must give to the PGH recipient written instructions stating the following:

(a) the date on which the referral was made;

(b) the name, address, and telephone number of the referring PGH provider;

(c) the name and address of the consultant; and

(d) the date and time of the appointment if one has been made (otherwise, a direction that an arrangement has been made for the consultant to make the appointment).

(3) Whenever a referral is made, the PGH provider must give to the consultant written notice containing the following:

(a) the information required by Subsection (D)(2) above, which may be a copy of the instructions given to the recipient;
(b) the name, address, telephone number, 17-digit Medicaid identification number from the recipient's Eligibility Card, and date of birth of the PGH recipient referred; and
(c) a brief statement indicating the reason for the referral, including any comments or instructions addressed to the consultant.

(4) Subsection 418.409(D), relative to inquiry into delivery problems, applies to referrals.

(5) The PGH Referral Form is a multi-copy form designed to facilitate compliance with this section and with Section 418.409 (relative to monitoring and follow-up). A PGH provider that has a record-keeping and follow-up system that it wishes to retain may submit a request for a waiver, accompanied by a detailed description of its system, to the PGH Program Director in the Medical Division. If the Program Director determines that the provider's system records the same information as required by the Referral Form, and is otherwise adequate for the purposes of these regulations, he shall issue a waiver. If the PGH provider does not obtain a waiver, the Department requires the use of the PGH Referral Form.

418.409: Monitoring and Follow-Up

An essential element of the PGH program is the establishment of systems and procedures by which the Department will verify that PGH recipients are receiving the PGH services to which they are entitled, take corrective action when recipients are found not to be receiving those services, and acquire adequate evidence that those duties are being performed. Accordingly, PGH providers must undertake the duties set forth in this section.

(A) Certification of Health Assessment. Each claim for a complete health assessment must include a certification by the PGH provider that all of the elements of the applicable screening package have been performed. The Department recognizes that there may be a rare situation in which a provider might have to omit a procedure for one of the following two reasons.

(1) Omission of Procedure That Is Not Medically Necessary. When a PGH provider omits the performance of a procedure from a health assessment because, in the provider's professional judgment, there is no medical necessity to perform the procedure, the provider must state that he has omitted the procedure. He must cite the procedure and the reason for concluding that there is no medical necessity for the performance of the procedure. The statement must accompany the claim for payment, and the claim must be submitted under the appropriate code for a partial health assessment listed in Subsection 418.421(A).

(2) Omission of Procedure Because of Impossibility to Perform It. When a PGH provider omits the performance of a procedure from a health assessment because it is impossible to perform the procedure,

the provider must state that he has omitted the procedure. If the reason of impossibility is based on recipient noncompliance, the provider must report the name of the recipient to the Department's PGH specialist. The provider must also prepare a statement describing his efforts to overcome the problem. The statement must accompany the claim for payment. The claim must be submitted under the appropriate code for a partial health assessment listed in Subsection 418.421(A). If a laboratory or other provider to whom a referral was made fails to perform the procedure, the PGH provider must nevertheless ensure the performance of the procedure (e.g., by making another referral appointment with a different laboratory or other provider). The Department will disallow any claim for which the reason of impossibility is the failure of a laboratory or other referral provider to perform the procedure.

(B) Appointments with PGH Providers. When a PGH recipient fails to appear for a second or subsequent appointment with a PGH provider, the provider must make attempts to arrange another appointment, by making written or telephone contacts with a responsible adult in the recipient's household. The provider must record the dates, natures, and results of the efforts. If the efforts are unsuccessful, of if the recipient fails to appear for the rescheduled appointment, the provider must inform the Department's PGH specialist.

(C) Appointments with Consultants. When a referral has been made, the PGH provider must ascertain, promptly after the date of the appointment with the consultant, whether the recipient appeared for the appointment and whether treatment has been initiated. If the recipient fails to appear, the provider must make attempts to arrange a second appointment, by making written or telephone contacts with a responsible adult in the recipient's household and with the consultant. The provider must record the dates, natures, and results of the efforts. If the efforts are unsuccessful, or if the recipient fails to appear for the rescheduled appointment, the provider must inform the Department's PGH specialist. When the recipient keeps an appointment with a consultant, the provider must obtain and record the consultant's report.

(D) Inquiry into Delivery Problems. A PGH provider must determine, by inquiry, whether PGH recipients are hindered in obtaining PGH services because of a need for translation, transportation, child care, or counseling, or because of any other circumstances or conditions that may impede the delivery of PGH services. A provider must promptly notify the Department's PGH specialist of any such circumstances or conditions and must urge the recipient to request the assistance of the Department's PGH specialist. Notification to the PGH specialist may be made by completing and mailing the appropriate section of the PGH Referral Form or by telephone. Notification by telephone must be noted in the recipient's record.

(E) Medical and Other Records. A PGH provider must create and maintain a centralized record for every PGH recipient whose care he undertakes. The record must contain the date, nature, and extent of services furnished directly or by referral, in accordance with applicable Medical Assistance Program regulations governing medical records generally. There must also be a record that contains documentation of the efforts of the provider to comply with the provisions of this Chapter 418.000, including those relative to appointments, referrals, and billing.

418.410: PGH Specialists

PGH specialists are located in the Department's Community Service Area Offices (CSAOs). Each PGH specialist works under the supervision of the PGH Program in the Medical Division. The duties of PGH specialists are specified below.

(A) Outreach. PGH specialists supplement the efforts of Assistance Payments workers to explain the PGH Program and its advantages to eligible recipients who are not yet committed to the program and to encourage maximum utilization of the program by all eligible members of recipients' households. The specialists also serve as a resource to social-service workers in the Massachusetts Department of Social Services.

(B) Assistance. PGH specialists assist those recipients who need or request further outreach and information to choose and make appointments with PGH providers (whenever possible) and to overcome barriers that hinder receipt of satisfactory and comprehensive health care. The PGH specialists also identify eligible persons who are in need of those health services provided under the authority of Title V of the Social Security Act, inform such persons about the services, and make referrals whenever appropriate.

(C) Liaison. PGH specialists maintain liaison between the Medical Division and local health-care providers. Their liaison duties include the promotion of provider participation, the provision of assistance to providers, and the development of provider alternatives.

(D) Follow-Up. PGH specialists must follow up in all cases in which a recipient has received assistance from Department staff to obtain health-care services, in order to ensure that services were received within a prescribed time period and were satisfactory.

(E) Documentation. PGH specialists create and maintain records designed to identify the status of recipients in the PGH Program.

(F) Promotion. PGH specialists promote interest in the PGH Program among recipients and providers through personal contact with recipients, public-interest advertising, promotional events, and contact with public and private agencies and groups.

(106 CMR 418.411 through 418.420 Reserved)

418.421: Claims for Health Assessments

(A) Fees for Health Assessments. The following fee schedule conforms to the one adopted by the Massachusetts Rate Setting Commission for health-assessment services furnished by PGH providers in accordance with the Medical Periodicity Schedule and with the regulations in this Chapter 418.000. Correct use of the procedure codes is essential to the proper operation of the tracking mechanisms established by the Department.

Procedure Code	Procedure Description	Allowable Fee
9040	Health assessment performed, no further diagnosis or treatment indicated	$ 25.00*
9060	Partial health assessment performed, no further diagnosis or treatment indicated	I.C.**
9041	Health assessment performed, further diagnosis or treatment indicated for vision problem	25.00*
9061	Partial health assessment performed, further diagnosis or treatment indicated for vision problem	I.C.**
9042	Health assessment performed, further diagnosis or treatment indicated for dental problem	25.00*
9062	Partial health assessment performed, further diagnosis or treatment indicated for dental problem	I.C.**
9043	Health assessment performed, further diagnosis or treatment indicated for hearing problem	25.00*
9063	Partial health assessment performed, further diagnosis or treatment indicated for hearing problem	I.C.**
9044	Health assessment performed, further diagnosis or treatment indicated for lead poisoning problem	25.00*
9064	Partial health assessment performed, further diagnosis or treatment indicated for lead poisoning problem	I.C.**

* The former fee of $20.00 for the designated procedures has been raised to $25.00, effective for September 1, 1979 dates of service.

** Individual consideration.

Procedure Code	Procedure Description	Allowable Fee
9045	Health assessment performed, further diagnosis or treatment indicated for two or more of the problems specified for Procedure Codes 9040 through 9044 or for an unspecified problem or problems	$ 25.00*
9065	Partial health assessment performed, further diagnosis or treatment indicated for two or more of the problems specified for Procedure Codes 9040 through 9044 or for an unspecified problem or problems	I.C.**

* The former fee of $20.00 for the designated procedures has been raised to $25.00, effective for September 1, 1979 dates of service.

** Individual consideration.

(B) Fees for Partial Health Assessments. The Department will review individually all claims and certifications for partial health assessments based on the omission of a procedure that was either not medically necessary or impossible to perform, and will grant or deny these claims based on whether the Department agrees that there was no medical necessity or that it was impossible to perform the procedure. Review of all claims for partial health assessments based on the omission of a procedure that was not medically necessary will be performed by a physician. If the Department denies a certification of no medical necessity or impossibility, the claim will be disallowed unless the PGH provider performs or arranges for the performance of the procedure that had previously been omitted. The Department will notify the provider in all such instances. If a claim has been disallowed, the Department will notify the provider in a time period not to exceed seven days after the date of denial. The provider cannot submit, and the Department will not allow, another claim for the same service submitted under any of the office codes.

(C) Health Assessments Performed by Nurse Practitioners. Physicians and physician groups, in submitting claims for the health-assessment procedure codes listed above, may submit claims when some of the health-assessment services were furnished by a qualified nurse practitioner who is operating under the provider's direct supervision in the office setting, provided that this method of performing health assessments is identical to that used for patients who are not Medical Assistance recipients. The only services furnished by a nurse practitioner for which the Department will pay are health assessments (Procedure Codes 9040 through 9045 and 9060 through 9065). A nurse practitioner must hold a current license from the Massachusetts Board of Registration in Nursing to practice professional nursing in the Commonwealth of Massachusetts. In addition to being a registered nurse, a nurse practitioner must have completed a specialized educational program that includes training in the following areas:

(1) assessment of the physical, emotional, and developmental status of the individual and his family;
(2) assessment of the environmental status of the community and its impact on health;
(3) analysis of health behavior related to personality, life style, and culture;
(4) provision of primary care through diagnosis, clinical judgment, and management to restore, maintain, and improve health status;
(5) roles of teaching, counseling, and advocacy;
(6) collaboration or coordination with other health-care providers and community organizations;
(7) initiation of or participation in clinical nursing research and in the application of research findings to practice; and
(8) evaluation of the effectiveness of family nursing.

418.422: Claims for Laboratory Services

The following laboratory services, which are included in the Medical Periodicity Schedule, are reimbursable in addition to the health-assessment services, even when furnished by the same provider who furnished the health assessment.

Service Code	Procedure Description	Allowable Fee
101126	Hematocrit	$ 2.00
101156	Hemoglobin, qual. (any fluid)	2.00
101347	Urinary (blood, ketones, protein, glucose, pH) dip stick	1.00
101161	Urinalysis, routine	4.00
101019	Cultures (routine)	5.00*
101137	Sickle cell prep.	6.00
101099	Mailing blood lead specimen	1.00**
101012	Hinton test (syphilis serology)	5.00
101341	Triglycerides	10.00
101233	Cholesterol, total	5.00
101402	Pap smear (vaginal and cervical smears)	6.00

* When billing for a GC culture, use this service code.

** Send to: State Lead Poison Prevention Program
305 South Street
Jamaica Plain, MA 02130

418.423: Claims for Other Reimbursable Services

The following service, which is included in the Medical Periodicity Schedule, is reimbursable in addition to the health-assessment and laboratory services, even when furnished by the same provider who furnished the health assessment.

Procedure Code	Procedure Description	Allowable Fee
9350	Hearing test by audiometer	$ 5.00

(106 CMR 418.424 through 418.450 Reserved)

418.451: Project Good Health Medical Periodicity Schedule

(A) The Project Good Health Medical Periodicity Schedule was developed by the Massachusetts Chapter of the American Academy of Pediatrics. Special consultation regarding the screening for lead poisoning was provided by the Massachusetts Childhood Lead Poisoning Prevention Program of the Massachusetts Department of Public Health. The content and periodicity were reviewed by a special task force made up of representatives of the various types of primary-care providers (i.e., pediatricians, family physicians, community health centers, and health maintenance organizations).

(B) The Medical Periodicity Schedule reflects the following minimum screening services required to be performed for a PGH recipient:

(1) health and developmental history (physical and mental);
(2) developmental assessment;
(3) unclothed physical examination;
(4) immunizations that are appropriate for age and health history;
(5) vision testing;
(6) hearing testing;
(7) assessment of nutritional status; and
(8) laboratory procedures appropriate for age and population group.

(C) The Medical Periodicity Schedule also reflects the periodicity for screening services recommended to the Department by leading representatives of the Massachusetts medical community. Additional laboratory tests should be performed as determined necessary in the medical judgment of the PGH provider. Section 418.422 contains the list of reimbursable laboratory services. When a recipient has had infrequent health-assessment examinations, the provider must furnish the additional tests and screens necessary to bring the recipient up to date with his preventive health care according to the Medical Periodicity Schedule.

(D) The PGH provider must perform or ensure the performance of all components of the health assessment appropriate to the recipient's age,

including the listed laboratory tests and hearing tests by audiometer, that are outlined in the Medical Periodicity Schedule.

(E) The authority of the Department under M.G.L. c. 118D, s. 4, to formulate standards and criteria for the Medical Assistance Program expressly excludes "medical standards and criteria". This schedule is not intended to and does not establish a standard of care for purposes of tort liability. If the schedule is amended, the Department will send the amendments to PGH providers.

NOTE: The footnotes to the Medical Periodicity Schedule are printed at the end of the schedule.

Age	Service	Laboratory
Newborn	a. Initial history and physical examination of normal newborn [1]	
	b. Discharge history and physical examination of normal newborn [2]	
2-6 weeks	a. Health history to include health of family, pregnancy, delivery, and neonatal period (or interval history if neonatal examinations listed above were performed by the same doctor)	
	b. Developmental assessment [3]	
	c. Unclothed physical examination	
	d. Assessment of nutritional status [4]	
	e. Appropriate immunizations [5]	
	f. Hearing and vision tests (gross) [6]	
8-10 weeks	a. Interval history	
	b. Developmental assessment [3]	
	c. Unclothed physical examination	
	d. Assessment of nutritional status [4]	
	e. Appropriate immunizations [5]	
	f. Hearing and vision tests (gross) [6]	

Age	Service	Laboratory
4 months	a. Interval history	
	b. Developmental assessment [3]	
	c. Unclothed physical examination	
	d. Assessment of nutritional status [4]	
	e. Appropriate immunizations [5]	
	f. Hearing and vision tests (gross) [6]	
6 months	a. Interval history	
	b. Developmental assessment [3]	
	c. Unclothed physical examination	
	d. Assessment of nutritional status [4]	
	e. Appropriate immunizations [5]	
	f. Hearing and vision tests (gross) [6]	
9 months	a. Interval history	a. Hematocrit or hemoglobin (if not done previously)
	b. Developmental assessment [3]	
	c. Unclothed physical examination	
	d. Assessment of nutritional status [4]	
	e. Appropriate immunizations [5]	
	f. Hearing and vision tests (gross) [6]	
1 year	a. Interval history	a. EP [7]
	b. Developmental assessment [3]	b. TB test [8]
	c. Unclothed physical examination	

Age	Service	Laboratory
	d. Assessment of nutritional status [4]	
	e. Appropriate immunizations [5]	
	f. Hearing and vision tests (gross) [6]	
15 months	a. Interval history	a. EP [7,9]
	b. Developmental assessment [3]	b. Additional lab tests (if not previously performed)
	c. Unclothed physical examination	
	d. Assessment of nutritional status [4]	c. Hematocrit or hemaglobin
	e. Appropriate immunizations [5]	
	f. Hearing and vision tests (gross) [6]	
20 months	a. Interval history	a. EP (either at 20 months or 2 years) [7, 10]
	b. Developmental assessment [3]	
	c. Unclothed physical examination	
	d. Assessment of nutritional status [4]	
	e. Appropriate immunizations [5]	
	f. Hearing and vision tests (gross) [6]	
2 years	a. Interval history	a. EP [7, 9]
	b. Developmental assessment [3]	
	c. Unclothed physical examination	
	d. Assessment of nutritional status [4]	

Age	Service	Laboratory
	e. Appropriate immunizations [5]	
	f. Hearing and vision tests (gross) [6]	
30 months	a. Interval history	
	b. Developmental assessment [3]	
	c. Unclothed physical examination	
	d. Assessment of nutritional status [4]	
	e. Appropriate immunizations [5]	
	f. Hearing and vision tests (gross) [6]	
3 years	a. Interval history	a. Urinalysis and/or culture (if indicated) [12]
	b. Developmental assessment [3]	b. EP [7, 9]
	c. Unclothed physical examination	
	d. Blood pressure [11]	
	e. Assessment of nutritional status [4]	
	f. Hearing and vision tests (gross) [6]	
	g. Immunizations (if needed)	
4 years	a. Interval history	a. TB test [8]
	b. Developmental assessment [3]	b. EP (both "high-risk" and "low-risk" children) (this can be done at the four- or
	c. Unclothed physical examination [13]	
	d. Blood pressure	
	e. Assessment of nutritional status [4]	

Age	Service	Laboratory
	f. Hearing test [14] g. Vision test [15] h. Immunizations (if needed)	five-year visit) [7, 9, 10]
5 years	a. Interval history b. Developmental assessment [3] c. Unclothed physical examination [13] d. Blood pressure e. Assessment of nutritional status [4] f. Hearing test [14] g. Vision test [15] h. Immunizations (if needed)	a. Cholesterol [16] b. Urinalysis and/or culture (if indicated) [12]
6 years	a. Interval history b. Developmental assessment [3] c. Unclothed physical examination d. Blood pressure e. Assessment of nutritional status [4] f. Hearing test [14] g. Vision test [15] h. Immunizations (if needed)	a. TB test [8] b. Urinalysis and/or culture (if indicated) [12]

Age	Service	Laboratory
7 years	a. Interval history	
	b. Developmental assessment [3]	
	c. Unclothed physical examination	
	d. Blood pressure	
	e. Assessment of nutritional status [4]	
	f. Vision test [15]	
	g. Immunizations (if needed)	
8 years	a. Interval history	
	b. Developmental assessment [3]	
	c. Unclothed physical examination	
	d. Blood pressure	
	e. Assessment of nutritional status [4]	
	f. Vision test [15]	
	g. Immunizations (if needed)	
	h. Health education and counseling [17]	
9 years	a. Interval history	a. Urinalysis and/or culture (if indicated) [12]
	b. Developmental assessment [3]	
	c. Unclothed physical examination	
	d. Blood pressure	
	e. Assessment of nutritional status [4]	

Age	Service	Laboratory
	f. Hearing test [14] g. Vision test [15] h. Immunizations (if needed) i. Health education and counseling [17]	
10 years	a. Interval history b. Developmental assessment [3] c. Unclothed physical examination d. Blood pressure e. Assessment of nutritional status [4] f. Hearing test [14] g. Vision test [15] h. Immunizations (if needed) i. Health education and counseling [17] j. Assessment of mental and emotional health status	a. Urinalysis and/or culture (if indicated) [12]
12 years	a. Interval history b. Developmental assessment [3] c. Unclothed physical examination d. Blood pressure e. Assessment of nutritional status [4] f. Vision test [15] g. Immunizations (if needed)	a. Sickle cell test [18] b. Hematocrit or hemoglobin c. TB test [8] d. Urinalysis and/or culture (if indicated) [12]

Age	Service	Laboratory
	h. Health education and counseling [17] i. Assessment of mental and emotional health status	
14 years	a. Interval history b. Developmental assessment [3] c. Unclothed physical examination d. Blood pressure e. Assessment of nutritional status [4] f. Hearing test [14] g. Vision test [15] h. Immunizations (if needed) i. Health education and counseling [17] j. Pelvic examination for girls (optional, depending on maturity and sexual activity) k. Assessment of mental and emotional health status	a. Pap smear for girls [19] b. GC culture [19] c. TB test [8] d. Urinalysis and/or culture (if indicated) [12] e. Serology test [20]
16 years	a. Interval history b. Developmental assessment [3] c. Unclothed physical examination d. Blood pressure e. Assessment of nutritional status [4]	a. Pap smear for girls [19] b. GC culture [19] c. Urinalysis and/or culture (if indicated) [12]

Age	Service	Laboratory
	f. Vision test [15] g. Immunizations (if needed) h. Health education and counseling [17] i. Pelvic examination for girls (optional, depending on maturity and sexual activity) j. Assessment of mental and emotional health status	d. Serology test [20]
18 years	a. Interval history b. Developmental assessment [3] c. Unclothed physical examination d. Blood pressure e. Assessment of nutritional status [4] f. Vision test [15] g. Immunizations (if needed) h. Health education and counseling [17] i. Pelvic examination for girls j. Assessment of mental and emotional health status	a. Pap smear for girls b. GC culture c. Urinalysis and/or culture (if indicated) [12] d. Serology test [20]
20 years	a. Interval history b. Developmental assessment [3] c. Unclothed physical examination	a. Pap smear for girls b. GC culture

Age	Service	Laboratory
	d. Blood pressure	c. Urinalysis and/or culture (if indicated)[12]
	e. Assessment of nutritional status[4]	d. Serology test[20]
	f. Hearing test[14]	
	g. Vision test[15]	
	h. Immunizations (if needed)	
	i. Health education and counseling[17]	
	j. Pelvic examination for girls	
	k. Asseessment of mental and emotional health status	

1. This visit should be billed for according to the fee schedule in Section 418.421.

2. When billing for this visit, use code 019074 from the Fee Schedule for Physicians and Dentists (revised July 1, 1976).

3. Developmental assessment including examinations of eye/hand co-ordination, gross motor function, motor skills, speech development, and behavior development.

4. A special supplement on assessment of nutritional status, recommended by the Massachusetts Nutrition Board, is being sent to all PGH providers.

5. Immunizations according to the recommendations of the American Academy of Pediatrics and the Massachusetts Department of Public Health..

6. Discussion with parent or guardian, and observations in the office concerning child's response to sound and ability to follow moving objects visually.

7. The EP (erythrocyte protoporphyrin) method of testing for lead poisoning is endorsed by the U.S. Center for Disease Control. The EP test has the added benefit of detecting iron deficiency. It is recommended that sufficient blood be obtained at the time of the child's visit for the EP test as well as for blood lead and hematocrit or hemoglobin, if the provider feels it is indicated. The provider should perform the EP test as frequently as medically indicated, in addition to the frequency recommended in the schedule.

8. The TB tine test should be done at one year of age, at least once between the ages of four and six, and, again, once between the ages of 13 and 15, unless the provider believes greater frequency of testing is desirable.

9. The EP test should be performed if the child lives in a "high-risk" community (i.e., one with a population over 100,000).

10. The EP test should be performed if the child lives in a "low-risk" community (i.e., one with a population under 100,000).

11. The routine physical examination should include blood pressure beginning at the age of three and at each PGH health assessment thereafter.

12. Urinalysis and/or culture should be performed on an asymptomatic child one time between the ages of three and five, and at three-to-five-year intervals thereafter.

13. Fundoscopic examination of the eye should begin at the age of four and should continue thereafter as part of the physical examination.

14. A hearing test by audiometer should be given one time between the ages of four and six and repeated at five-year intervals (air-conduction testing at the following frequencies: 500 Hz, 1000 Hz, 2000 Hz, 3000 Hz, and 4000 Hz).

15. Vision may be tested using vision cards (Allen cards) (for pre-school children only, Snellen Chart, or Titmus machine or equivalent. If the child's vision is satisfactory, the test should be repeated every two or three years.

16. Cholesterol test when family history indicates.

17. Introduction to health education and counseling to include information appropriate to age on: growth and development, tobacco, alcohol and drugs, sexuality, accidents, role in family, religion, automobiles, diet, school, and the like.

18. Sickle cell test only once if indicated by ethnicity. When possible, it is advisable to perform C6PD examinations on appropriate children at the same time as the sickle cell test.

19. If pelvic examination is done at this visit.

20. For sexually active boys and girls.

418.452: Project Good Health Dental Periodicity Schedule

All PGH recipients should, beginning at age three, receive annual dental examinations with diagnostic radiographs, preventive services, and appropriate treatment in accordance with the regulations governing dental services under the Medical Assistance Program.

REGULATORY AUTHORITY

106 CMR 418.000: M.G.L. c. 18, s. 10; M.G.L. c. 118E, s. 4.

Department of Public Welfare

Medical Assistance Program

Dental Services

The Comonwealth of Massachusetts Department of Public Welfare ....

106 CMR is amended by repealing 106 CMR 463.000: Conditions of Participation--Guidelines for Dental Care, and 106 CMR 464.000: Dental Services, and adding the following chapter:

106 CMR 420.000: MEDICAL ASSISTANCE PROGRAM: DENTAL SERVICES

Section

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420.626	Fee Schedule of Hospital Services:	Unlisted Procedures

(106 CMR 420.001 through 420.400 Reserved)

420.401: Introduction

(A) Dental services reimbursable under the Medical Assistance Program consist of those basic services essential for the prevention and control of dental diseases and the maintenance of oral health. The Department will pay only for those basic supportive treatments that are consistent with the regulations in this Chapter 420.000 and that have the greatest potential for long-term benefits.

(B) The regulations in this Chapter 420.000 specify the conditions of payment for services considered to be basic care for children and adults. Elective or cosmetic services that are not essential to the maintenance of oral health are not reimbursable.

420.402: Eligible Recipients

Dental providers participating in the Medical Assistance Program are responsible for confirming the eligibility of the recipient at the time of examination as well as each time services are provided.

(A) Medical Assistance Recipients.
(1) For Medical Assistance recipients under 21 years of age (categories of assistance 00, 02, 03, 06, 07, and 08), the Department pays for dental services consistent with the Department's regulations governing Project Good Health services.
(2) For Medical Assistance recipients 21 years of age or older (categories of assistance 00, 01, 02, 03, 05, 06, and 07), the Department pays for basic dental services.

(B) General Relief Recipients. The Department pays for basic dental services provided to General Relief recipients (category of assistance

04), when the services are provided in the dentist's office, a community health center, a dental-school clinic, or the recipient's place of residence. The Department does not pay for dental services provided to a General Relief recipient who is a hospital patient or who is treated in a hospital outpatient department or day surgery center.

420.403: Provider Eligibility: Participating Providers

Payment for services described in this Chapter 420.000 will be made only to providers of dental services who are participating in the Medical Assistance Program as of the date of service. The participating provider is responsible for all services claimed. In order to claim payment, the participating provider must be the dentist who actually performed the service, except in the following situations.

(A) A dentist who is in a group practice, or who performs services under contract to another dentist, or who is an employee of a licensed dental clinic, may direct payment to the group practice, the other dentist, or the clinic by authorizing that other person or entity to submit claims on his behalf, under the provisions of the Department's billing intermediary regulations. The dentist furnishing the services must be identified on claims for his services, and is fully responsible when this method of billing is used.

(B) A dental school may claim payment for services provided in its dental clinic.

(C) A community health center, hospital-licensed health center, health maintenance organization, or hospital outpatient department may claim payment for services provided in its dental clinic.

(D) A dental laboratory may claim payment for prosthetic material delivered to a salaried dentist as described in Subsection 420.404(E).

420.404: Provider Eligibility: In State

The following requirements apply when the dental provider is located in Massachusetts.

(A) Practitioner. A dentist is eligible to participate in the Medical Assistance Program if he is licensed to practice by the Massachusetts Board of Dentistry. Eligible dentists may be engaged in private practices that include, but are not restricted to, solo, partnership, or group practices.

(B) Health Maintenance Organization. A health maintenance organization with a dental-clinic specialty will be paid in accordance with the provisions of this Chapter 420.000.

(C) Community Health Center. A community health center that is certified to provide dental services will be paid in accordance with the provisions of this Chapter 420.000.

(D) Dental School. A dental school accredited by the American Dental Association is eligible to be a provider of dental services furnished in its teaching clinics by undergraduate and graduate dental students.

(E) Dental Laboratory. When a dentist's salary from a hospital, state institution, or nursing home includes compensation for professional services furnished to recipients, a dental laboratory designated by the dentist is eligible to be a provider and to be paid for the prosthetic materials supplied to the dentist.

(F) Hospital Outpatient Department and Hospital-Licensed Health Center. Dental services provided to recipients in a hospital outpatient department's dental clinic or a hospital-licensed health center will be paid for in accordance with the Department's regulations governing hospital outpatient department services.

(G) Other Dental Clinic. Only a dental clinic certified by the Massachusetts Department of Public Health is eligible to participate in the Medical Assistance Program. A dental clinic that limits its services to education and diagnostic screening is not eligible to participate.

(H) Specialist in Orthodontics. Orthodontic services are reimbursable only when the provider meets one of the following conditions.

(1) He is a dentist qualified through an American Dental Association two-year postgraduate training program in orthodontics. Listing as a Diplomate of the American Board of Orthodontists, or membership or eligibility for membership in the American Association of Orthodontists shall be considered evidence of this educational requirement.

(2) It is a dental school with a two-year postgraduate training program in orthodontics accredited by the Council on Dental Education of the American Dental Association.

(3) He has received approval of demonstrated competence by an Orthodontic Review Committee appointed by the Department. For approval, the Orthodontic Review Committee requires the following qualifications:

(a) a statement of undergraduate and graduate orthodontic training;

(b) orthodontic clinic and treatment experience;

(c) demonstration of a minimum of four cases of severe and handicapping malocclusion that have been treated or are in the process of completion, with pertinent records; and

(d) agreement that the Orthodontic Review Committee reserves the right to examine any patient at the office of the applicant, with the consent of the patient.

420.405: Provider Eligibility: Out of State

A dentist located outside of Massachusetts is eligible to be a participating provider and to be paid for dental services provided to Massachusetts recipients only if he is licensed to practice by his state's appropriate board of registration, and if he meets the specific provider eligibility requirements listed in Section 420.404.

420.406: Dental Services Provided Out of State

(A) The services of an out-of-state dental provider are reimbursable under the following circumstances:

(1) the recipient is temporarily out of state and is in need of dental care; or

(2) the recipient lives in an area of Massachusetts that borders on another state, and dental care is more readily available in the adjacent state.

(B) When a dentist recommends that a recipient be referred to an out-of-state dentist for consultation or treatment, the referring dentist must submit a prior-authorization request, including the reason for the recommendation, to the Department's Dental Advisor (see Section 420.409).

420.407: Fee Schedule Explanation

(A) Introduction. The Massachusetts Rate Setting Commission determines the maximum allowable fees for dental services. Payment is always subject to the conditions, exclusions, and limitations set forth in the regulations in this Chapter 420.000. Payment for a service shall be the lowest of the following:

(1) the provider's usual and customary fee;

(2) the provider's actual charge; or

(3) the maximum allowable fee listed in the fee schedule.

(B) Dental-Service Categories. Dental services and fees are grouped by major dental-service categories, namely diagnostic, preventive, restorative, endodontic, prosthodontic, office exodontic, orthodontic, other services, and hospital services.

(C) Undergraduate Teaching Dental Clinics. Allowable fees for dental services provided at teaching dental clinics by undergraduate dental students shall not exceed the lowest of the following:

(1) the clinic's usual fee to private patients;

(2) the clinic's actual charge; or

(3) 75 percent of the maximum allowable fee listed for the service in the fee schedule, rounded off to the nearest dollar.

(D) Graduate Teaching Dental Clinics. Allowable fees for dental services provided at dental clinics by graduate dental students shall not exceed the lowest of the following:

(1) the clinic's usual fee to private patients;
(2) the clinic's actual charge; or
(3) 85 percent of the maximum allowable fee listed for the service in the fee schedule, rounded off to the nearest dollar.

(E) Services for Children and Adults. The scope of reimbursable basic dental services is more extensive for children than for adults. This difference is found in the fee schedule. Where no amount is listed in the allowable fee column for adults, the service is not reimbursable for recipients aged 21 or over.

420.408: Nonreimbursable Circumstances

The Department will not reimburse a provider for dental services under any of the following circumstances:

(A) the services are provided in a state institution by a state-employed dentist or a dental consultant;

(B) the services are furnished by a provider whose salary from a hospital or affiliated medical-dental school includes compensation for professional services furnished to recipients; or

(C) under comparable circumstances, the provider does not customarily bill private patients who do not have health insurance.

420.409: Prior Authorization

(A) Introduction.

(1) For certain services (listed in Subsection (C) below), the Department requires that the provider obtain prior authorization. The provider must not begin to furnish the service until he has requested and received written prior authorization from the Department's Dental Advisor. A prior-authorization request must present the total treatment plan in detail.
(2) Emergency treatment for the relief of pain does not require prior authorization.
(3) Requests for prior authorization must be filed with the Dental Advisor of the Medical Division on the forms supplied by the Department for that purpose.

(B) Other Requirements for Payment.

(1) A prior authorization determines only the health-care necessity of the authorized service. Providers are still responsible for compliance with such other prerequisites for claiming payment as resort to health-insurance payment.

(2) The Department will not pay for a prior-authorized service when the recipient's Medical Assistance eligibility is terminated on or before the date of service.

(3) When the recipient's Medical Assistance eligibility is terminated prior to delivery of a special-order good, such as a denture, the provider may claim payment in accordance with the provisions of 106 CMR 450.231(B). (See 106 CMR 450.231(B) for special procedures in documenting recipient eligibility for special-order goods.)

(C) Services Requiring Prior Authorization. The following categories of service require prior authorization. Each of these service codes, which are designated on the fee schedule with the abbreviation "P.A.", is reimbursable only when the provider has obtained prior authorization from the Department:

(1) panoramic X ray for nonsurgical conditions (Service Code 060027);

(2) space maintainers and interceptive orthodontic treatment visits (Service Codes 060151, 060152, 060153, and 060154);

(3) crowns, posts, cores, and fixed bridgework (Service Codes 060271, 060272, 060273, 060274, 060277, and 060295);

(4) endodontics (root canals and apicoectomies) (Service Codes 060331, 060332, 060333, 060341, and 060342);

(5) prosthodontics (full dentures and partial dentures) (Service Codes 060511, 060512, 060531, 060532, 060533, 060534, 060537, and 060538);

(6) surgery performed in the office (Service Codes 060722, 060723, 060724, 060750, 060751, 060752, 060754, 060756, 060757, 060758, 060759, and, when elective, 060760);

(7) orthodontic treatment (full and limited) (Service Codes 060813, 060814, 060815, 060816, 060817, 060819, 060861, 060862, 060864, 060865, and 060881);

(8) mouth guard (Service Code 060910);

(9) dental treatment of a handicapped recipient in a hospital (Service Code 060942); and

(10) surgery performed in a hospital (Service Codes 060770, 060822, 060870, 061241, 062086, 062908, 062909, 062916, 062917, 062943, 062964, 062965, 062966, 062967, 062968, 062971, 062972, 062973, 062974, 062975, 062976, 062980, 062981, 062985, 062986, 062993, 062995, 062996, 062998, 063012, 063020, and, when elective, 069299). (See Subsection 420.427(C) for an exception to prior authorization.)

(D) Service Limitation Exceptions. A recipient is sometimes better treated by a service that is elsewhere defined as nonreimbursable, rather than by a more expensive allowable service. (See Sections 420.421 through 420.429.) For example, a posterior tooth may be adequately restored with pins (ordinarily a nonreimbursable service when performed on a posterior tooth) rather than with fabrication of a crown. Such treatment procedures are reimbursable when the provider obtains prior authorization.

420.410: Individual Consideration

Certain services listed in the fee schedule have the abbreviation "I.C." (indicating individual consideration) in the allowable fee column. Individual consideration means that a fee could not be established. All claims for services designated I.C. must be accompanied by a brief report of the services performed and the provider's usual charge. The rate of payment for an I.C. service shall be determined by the Department's Dental Advisor, based on the provider's descriptive report of the service furnished.

420.411: Recordkeeping Requirements

The fees for all dental services listed in this Chapter 420.000 include payment for preparation of the recipient's dental record. Services for which payment is claimed must be substantiated by clear evidence of the nature, extent, and necessity of care furnished to the recipient. Evidence may be in the form of examination results, diagnostic charting, description of treatment, radiographic record, or findings of other diagnostic tests. The dental record corresponding to the services claimed must include, but shall not be limited to, the following:

(A) the recipient's name and date of birth;

(B) the date of each service;

(C) the name and title of the person furnishing each service, if he is someone other than the dentist claiming payment;

(D) pertinent findings on examination;

(E) any medications administered or prescribed;

(F) any anesthetic agent administered; and

(G) a complete identification of treatment, including, when applicable, the tooth number and tooth surface or surfaces.

420.412: Report Requirements

When the procedure description in the fee schedule stipulates "with report only", a general written report or operative report must accompany the provider's claim. When the procedure is designated I.C., or when a code for an unlisted procedure is used, a general report that includes a diagnosis and a description of the service performed must accompany the claim. This report must be sufficiently detailed to enable the Department's professional reviewers to assess the extent and nature of services performed. An operative report must contain the

name of the operation, the name of the recipient, the date of the service, preoperative diagnosis, postoperative diagnosis, the names of the surgeon and of any assistant, the technical procedures performed, and the amount of time spent on the procedure.

420.413: Hospital Procedures

For surgical procedures performed on an inpatient or in a day surgery center of a licensed hospital, the fees include payment for preoperative diagnosis and postoperative care during the recipient's stay and are the maximum allowable amounts. Fees for extended preoperative care and extended postoperative care due to unusual circumstances will be given individual consideration by the Department's professional reviewer, if requested, and if an operative report and other pertinent documentation are attached to the claim.

(A) Surgical Assistants. No payment will be made to a surgical assistant for a procedure with a fee-schedule amount of less than $75.00. For other procedures, payment to a surgical assistant will be 15 percent of the allowable fee, with a minimum payment of $20.00.

(B) Multiple Procedures.

(1) In certain circumstances, only one operative procedure may be claimed for payment. For example, it is inappropriate to request payment for both alveoplasty and tuberosity reductions or for multiple tooth extractions and alveoplasty of an edentulous jaw.

(2) When two or more definitive procedures are performed in the same operative session, the procedure with the largest fee-schedule amount will be paid for at the full amount, and each additional procedure will be paid for at 50 percent of the amount.

(106 CMR 420.414 through 420.420 Reserved)

420.421: Service Descriptions and Limitations: Introduction

All dental services provided must be consistent with the descriptions and limitations specified in Sections 420.422 through 420.429. "The same period of treatment" means the time for those sequential visits necessary to perform all of the services identified from a diagnostic examination and treatment plan.

420.422: Service Descriptions and Limitations: Diagnostic Services

(A) Examination (Service Codes 060011 and 060012). An examination is reimbursable only for recipients under the age of 21. This service includes the preparation of charts, treatment plans, and reporting forms. Service Codes 060011 and 060012 are applicable for the initial visit only and annually thereafter. They are not applicable for a single emergency visit or for subsequent referral to a specialist.

(B) Emergency Dental Care (Service Code 060014). This service is intended to meet the limited emergency demands that may arise from the exigencies of dental practice. Service Code 060014 is used to identify an unlisted emergency procedure and may be claimed only once as an all-inclusive fee for treatment provided during the visit. An explanatory report is required when claiming payment for this service. No other services except radiographs are reimbursable with a visit for emergency dental care.

(C) Radiographs: Introduction. The limitations placed on radiographs are intended to confine radiation exposure of recipients to the minimum necessary to achieve satisfactory diagnosis for fundamental dental services. Radiographs must be of good diagnostic quality and, when submitted to the Department, must be properly mounted, dated, labeled for right and left views, and fully identified with the names of the dental office and the recipient. When X rays submitted to the Department are not of diagnostic quality, the provider may not claim payment for retake X rays requested by the Department's professional reviewer.

(D) Radiographs: Intraoral Films.

(1) Permanent Dentition: Full-Mouth X Rays (Service Code 060028). Unless prior authorization is obtained, full-mouth X rays are reimbursable only for recipients who are 13 years of age or older, and only once every three years. Full-mouth X rays (Service Code 060028) shall consist of a minimum of 14 periapical films plus posterior bitewing films.

(2) Mixed Dentition: Series of Ten X Rays (Service Code 060025). A series of X rays (Service Code 060025) for recipients aged six through 12 shall consist of ten intraoral films, either periapical or a combination of periapical and bitewing. Mixed-dentition series of X rays are reimbursable only once every three years, unless prior authorization is obtained.

(3) Primary Dentition (Service Codes 060022, 060023, and 060024). For recipients under the age of six, a survey not to exceed eight intraoral films, including two bitewings, is reimbursable only once (Service Codes 060022, 060023, and 060024). On other occasions for such recipients, X rays must be limited to bitewing and emergency periapical films.

(4) Supplementary X Rays (Service Codes 060022, 060023, and 060024). Two posterior bitewing X rays as an independent procedure are reimbursable only once per year. Periapical film may be taken for specific areas where extraction is anticipated, or when infection, periapical change, or an anomaly is suspected, or when otherwise directed by the Department. The provider may claim payment for individual intraoral X rays with Service Codes 060022, 060023, and 060024.

(5) Edentulous Recipient. X rays are not required and are not reimbursable when the provider is requesting prior authorization for full dentures for an edentulous recipient.

(E) Radiographs: Panoramic Radiographs.

(1) Surgical Conditions (Service Code 060029). Panoramic X-ray may be the preferred diagnostic film and is reimbursable without prior authorization in conjunction with certain surgical conditions. A descriptive report must accompany the claim. Those surgical conditions for which a panoramic X ray is reimbursable without prior authorization are:

(a) posterior impactions;
(b) teeth requiring extractions in more than one quadrant;
(c) large cysts or tumors that are not fully visualized by intraoral film or clinical examination;
(d) salivary-gland disease;
(e) maxillary-sinus disease;
(f) facial trauma;
(g) trismus where an intraoral film placement is impossible; and
(h) temporomandibular joint disease.

(2) Nonsurgical Conditions (Service Code 060027).

(a) For all diagnostic purposes except those listed in Subsection (E)(1) above, the provider must obtain prior authorization from the Department for panoramic X rays (Service Code 060027).

(b) Except in an unusual circumstance, the Department will not approve a panoramic X ray for prosthodontics and periodontics, or as a substitute for full-mouth intraoral X rays. The provider must submit with a request for prior authorization a statement justifying diagnostic need.

(F) Radiographs: Orthodontic X Rays (Service Codes 060813 through 060817). X rays as an independent procedure for orthodontic diagnostic purposes require prior authorization. Payment for X rays in conjunction with orthodontic diagnoses is included in the fees for the orthodontic service codes (Service Codes 060813 through 060817). Payment will not be made for additional radiographs from the same or another provider when required for orthodontic diagnosis.

(G) Full-Study Models (Service Code 060047). Full-study models are reimbursable only when requested by the Department as a part of prior authorization for treatment procedures. Payment for full-study models is included in the fees for orthodontic service codes. Payment will not be made for a full-study model as an independent procedure when prior authorization is granted for orthodontic diagnosis or treatment (Service Codes 060813 through 060865). Study models must be of good diagnostic quality and properly related in occlusion.

420.423: Service Descriptions and Limitations: Preventive Services

(A) Prophylaxis (Service Codes 060111 and 060112). Prophylaxis is reimbursable no more frequently than once a year, unless prior authorization is obtained. This service must include a scaling of the teeth, removal of acquired stains, and polishing of the teeth.

(B) Topical Fluoride Treatment (Service Code 060113). Topical fluoride treatment is reimbursable no more frequently than once a year, and only when provided to recipients under the age of 21. Topical fluoride treatment immediately follows prophylaxis and consists of isolation and drying of the dentition by segments and continuous topical application of an approved fluoride agent for a suitable time period.

(C) Space Maintainers (Service Codes 060151, 060152, and 060153). Space maintainers are reimbursable only for recipients under the age of 21 and only when the provider has obtained prior authorization. The provider must submit with a request for prior authorization a diagnostically adequate X ray.

(D) Interceptive Orthodontic-Treatment Visits (Service Code 060154). The goal of preventive or interceptive orthodontics is to prevent or minimize a developing malocclusion in recipients with primary or mixed dentition. The provider must obtain prior authorization for the number of adjustment visits in conjunction with a space-maintenance appliance.

420.424: Service Descriptions and Limitations: Restorative Services

(A) Amalgam Restorations (Service Codes 060214 through 060217).
(1) Cavity preparation must have an outline not only adequate for retention but extended to conform with the principles of prevention of recurrent caries.
(2) Payment will not be made for restorations attempted on primary teeth when early exfoliation (more than two-thirds of the root structure resorbed) is expected.
(3) Only one restoration per tooth surface is reimbursable.
(4) Service Code 060216 is to be used for fillings of three or more surfaces. No combination of services on a single tooth during the same period of treatment is reimbursable in excess of the fee for Service Code 060216.
(5) Service Code 060217 is to be used for each additional single-surface restoration performed during the same visit.

(B) Silicate Restorations (Service Code 060221).
(1) Silicate restorations are reimbursable only for primary or permanent anterior teeth and the buccal surfaces of the first bicuspids.
(2) Payment for two silicate restorations is the maximum allowable amount on a single tooth in the same period of treatment.
(3) Only one restoration for a mesial or a distal lesion is reimbursable, even though a buccal or a lingual approach is used.

(C) Composite Resin Restorations and Pins (Service Codes 060226, 060229, and 060231).
(1) Composite resin restorations are reimbursable only for permanent anterior teeth and the buccal surfaces of the first bicuspids.

(2) Payment for two composite resin restorations is the maximum allowable amount on a single tooth in the same period of treatment.
(3) Only one restoration for a mesial or a distal lesion is reimbursable, even though a buccal or a lingual approach is used.
(4) Reinforcing pins are reimbursable when used on permanent teeth where involvement of the incisal angle limits the retentive potential of cavity preparation. The maximum number of pins reimbursable per tooth is three.
(5) Restoration of a fractured anterior tooth with pins and composite material or its equivalent (Service Code 060231) is reimbursable when used in lieu of a full-crown restoration on a traumatically fractured anterior tooth with significant loss of the incisal third of the crown. The Department will pay a provider for this service when it is performed on any other teeth only after prior authorization has been obtained.

(D) Crowns, Posts, and Cores (Service Codes 060271, 060272, 060273, 060274, 060277, and 060283).
(1) All permanent crowns are reimbursable only when prior authorization has been obtained. The request must be justified by a sufficient number of radiographs of good diagnostic quality, dated and suitably mounted, to judge the general dental-health status.
(2) For crowns, the Department will grant prior-authorization requests only under unusual circumstances when the health of the remaining dentition warrants authorization, and then only when conventional restorations cannot be placed due to extensive loss of tooth structure, or when a composite restoration with pins will not be adequate.
(3) For posts, cores, and crowns on root-treated teeth, the Department will grant prior-authorization requests only when there is enough loss of coronal tissue to preclude a functional occlusion of the tooth.
(4) Payment will not be authorized for crowns provided solely for aesthetic reasons.
(5) Payment for a cast core (Service Code 060272) will be authorized only upon evidence of completion of successful endodontic treatment.
(6) A prefabricated post and core (Service Code 060273) is one that has been manufactured to be used as a substitute for a cast post and core.
(7) The Department will pay for stainless-steel crowns (Service Code 060283) for recipients under the age of 21. Prior authorization is not required.

(E) Fixed Bridgework (Service Codes 060295, 060296, and 060297).
(1) Fixed bridgework (Service Code 060295) is reimbursable only for recipients under the age of 21, and only when prior authorization has been obtained.
(2) Fixed bridgework is generally considered to be beyond the scope

of basic dental services. The Department will grant prior-authorization requests for fixed bridgework only in unusual circumstances, and only when it is evident that oral health is excellent.
(3) Repairs to existing fixed bridgework (using Service Code 060943 for an unlisted procedure) are reimbursable only when prior authorization has been obtained and on an individual-consideration (I.C.) basis.

420.425: Service Descriptions and Limitations: Endodontic Services

(A) Pulpotomy (Service Code 060322).
(1) A pulpotomy is reimbursable only for recipients under the age of 21.
(2) A pulpotomy is the complete removal of the coronal portion of the pulp to maintain the vitality of the tooth. It is limited to instances when the prognosis is favorable, and it must not be applied to primary teeth whose roots show signs of advanced resorption (more than two-thirds of the root structure resorbed).
(3) A pulpotomy is not reimbursable in conjunction with root-canal therapy in the same period of treatment.
(4) A pulpotomy is not reimbursable when used for the temporary relief of pain, pending authorization for endodontic treatment.

(B) Root-Canal Treatment (Service Codes 060331, 060332, and 060333).
(1) Root-canal treatment (Service Codes 060331, 060332, and 060333) requires prior authorization. This service is limited to the permanent dentition and then only when there is a favorable prognosis for the continued health of the remaining dentition. Requests for prior authorization must be justified by submitting a total diagnosis and treatment plan supported by sufficient radiographs of good diagnostic quality, dated and suitably mounted, to judge the general dental-health status. If the recipient will subsequently need a crown, the provider must state that fact on the request for prior authorization for root-canal treatment.
(2) Payment for root-canal treatment for upper or lower first molars is limited to recipients under the age of 21, unless, in the case of a recipient aged 21 or over, the need is for preservation of an abutment tooth, or where loss of the tooth would create a need for a partial denture as defined in Subsection 420.426(D)(1), or where other unusual circumstances exist.

(C) Apicoectomy (Service Codes 060341, 060342, 062967, and 062968).
(1) An apicoectomy requires prior authorization for payment.
(2) The fee for an apicoectomy with root-canal filling (Service Codes 060342 and 062967) is all-inclusive and includes payment for filling the canal or canals and removing the periapical pathological tissue in the same period of treatment.
(3) An apicoectomy as a separate procedure (Service Codes 060341 and 062968) follows root-canal treatment when the canal is not to be

reinstrumented. It is reimbursable only after sufficient time has elapsed to provide valid evidence of the need for the service. The fee for the procedure includes payment for the retrograde filling.

420.426: Service Descriptions and Limitations: Prosthodontic Services

(A) Denture Treatment Plan and Prosthetic History. All full and partial dentures require prior authorization. The provider must submit a complete treatment plan and prosthetic history with the prior-authorization request. A prosthetic history must include the following information, as applicable:

(1) identification of the teeth to be extracted;

(2) the length of time the recipient has been without natural teeth;

(3) the age and current status of previous or present denture or dentures;

(4) whether the Department paid for previous or present dentures; and

(5) the length of time the recipient has been without dentures.

If the recipient still has natural teeth, the provider must submit a current series of radiographs of good diagnostic quality, dated and suitably mounted, with the treatment plan. If the recipient has no remaining natural teeth, radiographs are not required. (See Subsection 420.422(D)(5).) The fee for full or partial dentures includes payment for all necessary adjustments within six months after insertion of the denture. The fee for a partial denture includes payment for all necessary clasps and rests, regardless of the number.

(B) Dentures for Recipients in Long-Term-Care Facilities.

(1) Dental services for recipients in long-term-care facilities must emphasize retention of the existing dentition consistent with the health and comfort of the recipient. Most persons in long-term-care facilities adapt better to repairs and other adjustments to existing dentures rather than to extractions or new dentures.

(2) The provider must submit the following information with a prior-authorization request for dentures for a recipient in a long-term-care facility: a general statement of the recipient's level of medical care; the recipient's capacity to communicate and to cooperate; and a statement that the recipient has expressed a desire for the dentures.

(3) The Department will not authorize payment for dentures unless the recipient is capable of adjusting to a prosthesis. A dentist must not prescribe dentures without the express consent of the recipient. Neither the absence of teeth nor cosmetic benefit, alone or in combination, is considered to be a sufficient reason for dentures.

(C) Full Dentures (Service Codes 060511 and 060512).

(1) Only permanent dentures are reimbursable. When the provider requests initial full dentures following multiple extractions, generally a period of two months must elapse between the time of the extractions and the time the impressions are taken.

(2) Immediate upper dentures are reimbursable only when the following conditions are met.

(a) There are no more than six maxillary anterior teeth, and no more than one posterior tooth to be extracted at the time of insertion of the denture.

(b) Impressions for the immediate dentures were taken after a suitable period of healing in the region where the posterior teeth were extracted.

(3) Immediate lower dentures are not reimbursable.

(D) Partial Dentures (Service Codes 060531, 060532, 060533, 060534, 060537, and 060538).

(1) The Department will consider prior-authorization requests for partial-denture construction only if there are fewer than eight sound posterior teeth in good occlusion. Fixed bridges and partial or full dentures when present will be counted as occluding teeth.

(2) The Department may also consider a request for a partial denture when the recipient is missing anterior teeth.

(3) The provider must submit to the Department an outline of the design of the denture, including the identity of the teeth to be replaced and the teeth to be clasped, and dated and suitably mounted radiographs of the remaining teeth.

(4) Design of the prosthesis must be as simple as possible, consistent with the basic principles of prosthodontics.

(5) The responsible dentist must send to the Department a signed certification that all carious teeth are functionally restored and that the supporting structures are in good health.

(E) Replacement of Dentures. The Department will not grant a prior authorization for the replacement of dentures previously paid for by the Department that are lost or broken beyond repair except in extraordinary circumstances. Such factors as the age of the recipient, the length of time that the recipient has been edentulous, the length of time that the recipient has been without dentures, and the current status of the dentures to be replaced may justify payment for the replacement of dentures. The Department will not authorize payment for the replacement of dentures if the recipient's denture history reveals any of the following conditions:

(1) repair or reline will make the existing denture usable;

(2) any or all of the dentures made previously have been unsatisfactory due to physiological causes that cannot be remedied;

(3) a psychosocial evaluation suggests that the recipient will not adjust satisfactorily to the new denture; or

(4) the edentulous recipient has been functioning without dentures for a substantial period of time.

420.427: Service Descriptions and Limitations: Exodontic Services

(A) Simple Extraction (Service Codes 060711, 060712, 060726, 060727, 062977, and 062978). Simple extraction is the removal of a permanent or deciduous tooth by the closed method or "forceps only" technique in which a flap is not retracted. All simple extractions may be performed as necessary. The Department may investigate an unusually heavy use of simple extractions in the primary dentitions to ensure that a significant health service has been provided.

(B) Surgical Removal of Erupted Tooth (Service Code 060721). Surgical removal of an erupted tooth is the removal of any erupted tooth by the open method that includes the retraction of a mucoperiosteal flap and the removal of substantial amounts of alveolar bone in order to effect the extraction or the sectioning of a tooth.

(C) Surgical Removal of Impacted Tooth.

(1) A provider must obtain prior authorization from the Department for the removal of impacted teeth, with the exception of symptomatic impacted teeth. Such teeth may be removed when clinically indicated.

(2) When a provider removes a symptomatic impacted tooth without prior authorization, he must submit with his claim an X ray and complete operative report to substantiate the need for the procedure. If the X ray does not substantiate the extent of the impaction, the reviewing authority may adjust the claim for a more appropriate service code to agree with the degree of impaction indicated by the X ray.

(3) The removal of a nonsymptomatic impacted tooth without prior authorization during the same surgical session in which a symptomatic impacted tooth is removed is reimbursable only if the provider submits documentation substantiating the urgent need for removal.

(4) Extraction of any impacted tooth in a follicular stage is not reimbursable except when appropriate for orthodontic treatment.

(5) A request for prior authorization for a surgical procedure must use the service code compatible with the location for delivery of the service. Prior authorization for payment of the treatment is indicative of the medical necessity for the service. When hospital service codes are authorized, the hospital admission is still subject to certification of hospital days by the Professional Standards Review Organization (PSRO).

(D) Surgical Removal of Tooth with Soft-Tissue Impaction (Service Codes 060722, 062975, and 062976). Surgical removal of a whole tooth with soft-tissue impaction is the removal of an unerupted or partially erupted tooth by the open method in which the major portion or all of the crown of the tooth was covered by a mucogingival tissue and no alveolar bone.

(E) Surgical Removal of Tooth with Partial Bony Impaction (Service Codes 060723, 062971, and 062972). Surgical removal of a whole tooth with partial bony impaction is the removal of any unerupted tooth by the open method in which it is necessary to expose any portion of the tooth by removal of the alveolar bone.

(F) Surgical Removal of Tooth with Complete Bony Impaction (Service Codes 060724, 062973, and 062974). Surgical removal of a whole tooth with complete bony impaction is the removal of any unerupted tooth by the open method in which it is necessary to expose the crown of the tooth by the removal of a significant amount of alveolar bone.

(G) Alveoplasty (Service Codes 060750, 060753, 062994, 062995, and 062996).

(1) Payment for alveoplasty procedures performed in conjunction with the extraction of teeth is included in the fee for the extraction procedures.

(2) Only when seven or more teeth per jaw are extracted is a separate fee for an alveoplasty allowable.

(3) The provider must obtain prior authorization from the Department for an alveoplasty as an independent procedure to correct deformities for an edentulous recipient.

(4) Payment for tuberosity reductions, when involved, is included in the fee for the alveoplasty procedure.

(H) Postoperative Visits (Service Code 060731). Payment for routine postoperative visits is included in the fee for surgical procedures. Payment for suture removal, irrigations, and spicule removal is included in the fee for surgical procedures. Postoperative follow-up in the office is an individual-consideration (I.C.) service that is reimbursable only for unusual services and only to ensure the safety and comfort of a postsurgical recipient. The provider must submit to the Department a report explaining the nature of the postoperative follow-up services and a description of the original surgery performed for individual-consideration review.

(I) Supernumerary Teeth. Extraction of supernumerary teeth may be identified with tooth numbers 61, 62, 63, and 64.

420.428: Service Descriptions and Limitations: Orthodontic Services

This section concerns Service Codes 060812 through 060882.

(A) Both limited and full orthodontic treatment are reimbursable only for recipients under the age of 21. However, regardless of the recipient's age, the Department will pay for the continuation of full orthodontic treatment as long as the recipient remains eligible for Medical Assistance, provided that initial treatment started before the recipient reached age 21.

(B) The provider must obtain prior authorization from the Department for all orthodontic treatment except for orthodontic consultation and retention following orthodontic treatment. The maximum number of retention visits that is reimbursable is five.

(C) Full orthodontic treatment is reimbursable only when the recipient has a severe and handicapping malocclusion.

(D) Limited orthodontic treatment (Service Code 060819) is orthodontic treatment of short duration that uses less-than-extensive mechanotherapy. This service will be approved for payment only when the following conditions are met:

(1) the recipient is at an age of development when treatment will be most beneficial;
(2) treatment should resolve the malocclusion completely; and
(3) there is no expectation of further maldevelopment that would later require full orthodontic treatment.

420.429: Service Descriptions and Limitations: Other Services

(A) Treatment of a Handicapped Recipient in a Hospital (Service Code 060942). The provider must obtain prior authorization for dental services other than surgery performed in the hospital, or hospital day surgery center. A written statement with complete justification for services must be submitted with the request for prior authorization. The provider will be paid according to the service codes in the fee schedule. The recipient's admission to the hospital will still be subject to certification of hospital days by the Professional Standards Review Organization (PSRO). In the instance of a conflict in the authorizations, the decision of the PSRO will prevail.

(B) Mouth Guard (Service Code 060910). A mouth guard is reimbursable only when the provider has obtained prior authorization. The Department will authorize a mouth guard only for a recipient under the age of 21, only if the recipient is engaged in an organized contact sport, and only when it is determined that the organization has no provision for the purchase of mouth guards for its participants.

(106 CMR 420.430 through 420.600 Reserved)

420.601: Fee Schedules: Explanation of Footnotes

The following footnotes are used in Sections 420.602 through 420.626:

1. Reimbursable for recipients under the age of 21.

2. Reimbursable for recipients aged 21 or over.

3. Prior authorization required (see Section 420.409).

4. Individual consideration (see Section 420.410).

420.602: Fee Schedule of Dental Services: Diagnostic Services

See Section 420.422 for limitations.

Service Code	Service Description	Allowable Fee	
		Child[1]	Adult[2]
	Examination, charting, and completion of reporting form (initial visit only, and annually thereafter; not reimbursable again when recipient is referred to a specialist)		
060011	Age 14 or over	$ 10.50	--
060012	To age 14	8.00	--
	Emergency dental care		
060014	Emergency treatment of dental pain (with report only) (dentist must describe the dental treatment furnished)	9.50	$ 9.50
	Radiographs		
060022	First intraoral bitewing or periapical film	3.00	3.00
060023	Second bitewing or periapical film	2.00	2.00
060024	Third or subsequent periapical film	1.00	1.00

Service Code	Service Description	Allowable Fee Child[1]	Allowable Fee Adult[2]
060025	Mixed dentition, series of ten intraoral films for recipients aged six through 12, reimbursable only once every three years	$ 14.00	--
060027	Panoramic X ray exclusive of bitewings (P.A.)[3]	17.00	$ 17.00
060028	Full-mouth X ray (including bitewings): minimum of 14 films for recipients aged 13 or over, reimbursable only once every three years	23.50	23.50
060029	Panoramic X ray exclusive of bitewings (surgical) (with report only)	17.00	17.00
060047	Full-study models, when indicated	12.00	12.00

420.603: Fee Schedule of Dental Services: Preventive Services

See Section 420.423 for limitations.

Service Code	Service Description	Allowable Fee Child[1]	Allowable Fee Adult[2]
	Prophylaxis (limited to once annually)		
060111	Age 14 or over	$ 14.00	$ 14.00
060112	To age 14	9.50	--
060113	Topical fluoride treatment (limited to once annually for recipients under the age of 21)	10.50	--
	Space maintainers		
060151	Fixed-band type, per quadrant (P.A.)[3]	56.00	--

Service Code	Procedure Description	Allowable Fee Child [1]	Allowable Fee Adult [2]
	Amalgam Restorations		
060214	One-surface filling	$ 10.00	$ 10.00
060215	Two-surface filling	14.00	14.00
060216	Three or more surfaces	18.00	18.00
060217	Each additional one-surface filling (performed at same visit)	6.00	6.00
	Silicate Restorations (anterior teeth only)		
060221	Silicate filling (amount reimbursable not to exceed two per tooth in the same period of treatment)	10.00	10.00
	Composite Resin Restorations (anterior permanent teeth only)		
060226	Composite restoration (amount reimbursable not to exceed two per tooth in the same period of treatment)	13.00	13.00
060229	Reinforcing pins, each pin (maximum of three)	4.00	4.00
060231	Restoration of fractured anterior tooth with pins and composite material (or equivalent)	41.00	41.00
	Crowns, Posts, and Cores		
060271	Acrylic-jacket crown (mounted X rays required) (P.A.) [3]	118.00	118.00
060272	Cast core (mounted X rays required) (P.A.) [3]	50.00	50.00
060273	Prefabricated post and core (mounted X rays required) (P.A.) [3]	45.00	45.00
060274	Porcelain-jacket crown (mounted X rays required) (P.A.) [3]	142.00	142.00
060277	Acrylic-veneer crown (mounted X rays required) (P.A.) [3]	166.00	166.00
060283	Stainless-steel crown	26.00	--
060291	Recementing loose inlay or crown	10.00	10.00

Service Code	Service Description	Allowable Fee Child[1]	Allowable Fee Adult[2]
060152	Fixed-band type, bilateral (P.A.)[3]	$ 80.00	--
060153	Acrylic, removable, bilateral (P.A.)[3]	64.50	--
060154	Treatment visit, interceptive orthodontics (P.A.)[3]	I.C.[4]	--

420.604: Fee Schedule of Dental Services: Restorative Services

See Section 420.424 for limitations.

Service Code	Service Description	Allowable Fee Child[1]	Allowable Fee Adult[2]
	Amalgam restorations		
060214	One-surface filling	$ 11.50	$ 11.50
060215	Two-surface filling	16.50	16.50
060216	Three or more surfaces	21.00	21.00
060217	Each additional one-surface filling (performed at same visit)	7.50	7.50
	Silicate restorations (anterior teeth only)		
060221	Silicate filling (amount reimbursable not to exceed two per tooth in the same period of treatment)	10.50	10.50
	Composite resin restorations (anterior permanent teeth only)		
060226	Composite restoration (amount reimbursable not to exceed two per tooth in the same period of treatment)	15.00	15.00

Service Code	Service Description	Allowable Fee Child[1]	Allowable Fee Adult[2]
060229	Reinforcing pins, each pin (maximum of three)	$ 5.00	$ 5.00
060231	Restoration of fractured anterior tooth with pins and composite material (or equivalent)	46.50	46.50
	Crowns, posts, and cores		
060271	Acrylic-jacket crown (mounted X rays required) (P.A.)[3]	134.00	134.00
060272	Cast core (mounted X rays required) (P.A.)[3]	58.00	58.00
060273	Prefabricated post and core (mounted X rays required) (P.A.)[3]	48.00	48.00
060274	Porcelain-jacket crown (mounted X rays required) (P.A.)[3]	164.50	164.50
060277	Acrylic-veneer crown (mounted X rays required) (P.A.)[3]	188.50	188.50
060283	Stainless-steel crown	29.50	--
060291	Recementing loose inlay or crown	11.50	11.50
	Bridgework		
060295	Bridgework per unit (mounted X rays required) (P.A.)[3]	188.50	--
060296	Replacing broken bridge facing, each	22.50	22.50
060297	Recementing loose bridge	18.50	18.50

420.605: Fee Schedule of Dental Services: Endodontic Services

See Section 420.425 for limitations.

Service Code	Service Description	Allowable Fee	
		Child[1]	Adult[2]
060322	Pulpotomy	$ 19.00	--
	Root canal (mounted X rays required; permanent teeth only)		
060331	Single-rooted tooth (P.A.)[3]	90.50	$ 90.50
060332	Double-rooted tooth (P.A.)[3]	131.50	131.50
060333	Triple-rooted tooth (P.A.)[3]	203.00	203.00
	Apicoectomy (including removal of periapical pathological tissue)		
060341	Separate procedure (P.A.)[3]	53.00	53.00
060342	With root-canal filling (P.A.)[3]	89.00	89.00

420.606: Fee Schedule of Dental Services: Prosthodontic Services

See Section 420.426 for limitations.

Service Code	Service Description	Allowable Fee	
		Child[1]	Adult[2]
	Full dentures (including all necessary adjustments)		
060511	Single full upper (P.A.)[3]	$202.00	$202.00
060512	Single full lower (P.A.)[3]	202.00	202.00
	Partial dentures (including all necessary adjustments; supporting X rays of good diagnostic quality, dated and suitably mounted, must accompany request)		
060531	Partial upper denture without clasps (P.A.)[3]	96.50	96.50

420.605: Fee Schedule of Dental Services: Endodontic Services

See Section 420.425 for limitations.

Service Code	Service Description	Allowable Fee	
		Child[1]	Adult[2]
060322	Pulpotomy	$ 18.00	--
	Root canal (mounted X rays required; permanent teeth only)		
060331	Single-rooted tooth (P.A.)[3]	85.00	$ 85.00
060332	Double-rooted tooth (P.A.)[3]	124.00	124.00
060333	Triple-rooted tooth (P.A.)[3]	191.00	191.00
	Apicoectomy (including removal of periapical pathological tissue)		
060341	Separate procedure (P.A.)[3]	50.00	50.00
060342	With root-canal filling (P.A.)[3]	84.00	84.00

420.606: Fee Schedule of Dental Services: Prosthodontic Services

See Section 420.426 for limitations.

Service Code	Service Description	Allowable Fee	
		Child[1]	Adult[2]
	Full dentures (including all necessary adjustments)		
060511	Single full upper (P.A.)[3]	$190.00	$190.00
060512	Single full lower (P.A.)[3]	190.00	190.00
	Partial dentures (including all necessary adjustments; supporting X rays of good diagnostic quality, dated and suitably mounted, must accompany request)		
060531	Partial upper denture without clasps (P.A.)[3]	91.00	91.00

Service Code	Service Description	Allowable Fee	
		Child[1]	Adult[2]
060532	Partial lower denture without clasps (P.A.)[3]	$ 96.50	$ 96.50
060533	Partial upper denture with necessary clasps and rests (P.A.)[3]	191.00	191.00
060534	Partial lower denture with necessary clasps and rests (P.A.)[3]	191.00	191.00
060537	Partial upper denture with bar, necessary clasps, and rests (P.A.)[3]	199.50	199.50
060538	Partial lower denture with bar, necessary clasps, and rests (P.A.)[3]	199.50	199.50
	Denture repairs		
060561	Repair of broken denture (no teeth involved)	20.00	20.00
060562	Repair of broken denture and replacing broken teeth, each tooth	8.50	8.50
060563	Repair of broken teeth on denture only, first tooth	21.00	21.00
060564	Replacing each additional tooth, same processing	8.50	8.50
060565	Adding tooth to partial denture to replace extracted natural tooth	35.00	35.00
060566	Each additional tooth, same processing	14.00	14.00
060568	Replacing broken clasp with new clasp on denture	34.00	34.00
060573	Reline denture, processed, each	72.00	72.00

420.607: Fee Schedule of Dental Services: Exodontic Services

The fees in this section include payment for the removal of sutures. See Section 420.427 for limitations.

Service Code	Service Description	Allowable Fee	
		Child[1]	Adult[2]
	Extraction with local anesthesia (with or without alveoplasty)		
060711	Single tooth	$ 10.50	$ 10.50
060712	Additional teeth at same sitting, each	7.50	7.50
060721	Surgical removal of erupted tooth (with report only)	21.00	21.00
	Extraction with general or intravenous anesthesia (with or without alveoplasty)		
060726	Single tooth	20.00	20.00
060727	Additional teeth at same sitting, each	7.50	7.50
	Surgery (see Subsection 420.427(C) for an exception to the prior authorization requirement)		
060722	Surgical removal of tooth with soft-tissue impaction (P.A.)[3]	36.00	36.00
060723	Surgical removal of tooth with partial bony impaction (P.A.)[3]	49.00	49.00
060724	Surgical removal of tooth with complete bony impaction (P.A.)[3]	83.00	83.00
060731	Postoperative follow-up (to surgery only) (with report only)	I.C.[4]	I.C.[4]
060733	Alveoplasty with seven or more extractions, maxilla	32.00	32.00

Service Code	Service Description	Allowable Fee Child[1]	Allowable Fee Adult[2]
060734	Alveoplasty with seven or more extractions, mandible	$ 32.00	$ 32.00
060750	Localized alveoplasty of edentulous jaw (P.A.)[3]	I.C.[4]	I.C.[4]
060751	Alveoplasty, independent procedure, maxilla (P.A.)[3]	I.C.[4]	I.C.[4]
060752	Alveoplasty, independent procedure, mandible (P.A.)[3]	I.C.[4]	I.C.[4]
060754	Ridge extension (with report only) (P.A.)[3]	I.C.[4]	I.C.[4]
060756	Frenectomy (with report only) (P.A.)[3]	I.C.[4]	I.C.[4]
060757	Removal of hypertrophied tissue (with report only) (P.A.)[3]	I.C.[4]	I.C.[4]
060758	Surgical exposure of unerupted tooth (with report only) (P.A.)[3]	I.C.[4]	I.C.[4]
060759	Gingivectomy, per quadrant (with report only) (P.A.)[3]	I.C.[4]	I.C.[4]
060760	All other surgery (with report and X rays) (P.A. if elective)[3]	I.C.[4]	I.C.[4]

420.608: Fee Schedule of Dental Services: Orthodontic Services

See Section 420.428 for limitations.

Service Code	Service Description	Allowable Fee Child[1]	Allowable Fee Adult[2]
	Orthodontic consultation (not including X rays, models, or photographs)		
060812	Independent procedure by an accredited orthodontist, once per six months	$ 13.50	--

Service Code	Service Description	Allowable Fee	
		Child[1]	Adult[2]
060734	Alveoplasty with seven or more extractions, mandible	$ 30.00	$ 30.00
060750	Localized alveoplasty of edentulous jaw (P.A.)[3]	I.C.[4]	I.C.[4]
060751	Alveoplasty, independent procedure, maxilla (P.A.)[3]	I.C.[4]	I.C.[4]
060752	Alveoplasty, independent procedure, mandible (P.A.)[3]	I.C.[4]	I.C.[4]
060754	Ridge extension (with report only) (P.A.)[3]	I.C.[4]	I.C.[4]
060756	Frenectomy (with report only) (P.A.)[3]	I.C.[4]	I.C.[4]
060757	Removal of hypertrophied tissue (with report only) (P.A.)[3]	I.C.[4]	I.C.[4]
060758	Surgical exposure of unerupted tooth (with report only) (P.A.)[3]	I.C.[4]	I.C.[4]
060759	Gingivectomy, per quadrant (with report only) (P.A.)[3]	I.C.[4]	I.C.[4]
060760	All other surgery (with report and X rays) (P.A. if elective)[3]	I.C.[4]	I.C.[4]

420.608: Fee Schedule of Dental Services: Orthodontic Services

See Section 420.428 for limitations.

Service Code	Service Description	Allowable Fee	
		Child[1]	Adult[2]
	Orthodontic consultation (not including X rays, models, or photographs)		
060812	Independent procedure by an accredited orthodontist, once per six months	$ 12.50	--

Service Code	Service Description	Allowable Fee	
		Child[1]	Adult[2]
	Orthodontic X rays		
060813	Full-mouth series or panoramic X rays with bitewings (P.A.)[3]	$ 23.50	--
060814	Lateral-jaw series (P.A.)[3]	19.00	--
060815	Cephalometric series (P.A.)[3]	19.00	--
	Orthodontic diagnosis		
060816	Diagnosis (including models, photographs, and X rays) (P.A.)[3]	68.50	--
060817	Initial fee (including diagnosis, models, photographs, and X rays) (P.A.)[3]	276.00	--
060819	Limited orthodontics (mounted X rays and models required) (P.A.)[3]	I.C.[4]	--
	Orthodontic treatment		
060861	Active, first year, including a retainer (P.A.)[3], per month	37.00	--
060862	Active, second year, including a retainer (P.A.)[3], per month	37.00	--
060864	Active, first half of third year if necessary, including a retainer (P.A.)[3], per month	37.00	--
060865	Second half of third year if necessary, including a retainer (P.A.)[3], per month	13.00	--
060881	Replacement retainer if necessary (P.A.)[3]	51.00	--
060882	Retention following orthodontic treatment, fee per visit (maximum of five)	15.00	--

420.609: Fee Schedule of Dental Services: Other Services

See Section 420.429 for limitations.

Service Code	Service Description	Allowable Fee	
		Child[1]	Adult[2]
060910	Mouth guard, processed and custom-fitted (P.A.)[3]	$ 37.00	--
060942	Dental treatment of handicapped recipient in hospital (with report only) (P.A.)[3]	I.C.[4]	I.C.[4]

420.610: Fee Schedule of Dental Services: Unlisted Procedures

Service Code	Service Description	Allowable Fee	
		Child[1]	Adult[2]
060943	Unlisted procedure (with report only) (P.A.)[3]	I.C.[4]	I.C.[4]

420.611: Fee Schedule of Hospital Services: Musculoskeletal System, Bones

Service Code	Service Description	Allowable Fee
	Partial ostectomy	
060621	Condylectomy, mandible	I.C.[4]
	Introduction	
060702	Insertion of wire (Kirschner wire) or pin (Steinmann's pin)	$ 33.50
060706	Removal of buried wire, pin, screw, metal band, rod, nail, or plate, superficial	I.C.[4]
060707	deep	I.C.[4]
	Grafts	
060770	Bone graft to face or skull, autogenous (P.A.)[3]	I.C.[4]
	Osteotomy	
060822	Mandible, bilateral for malocclusion (P.A.)[3]	449.50
	Osteoplasty	
060870	Osteotomy, mandible, bilateral sliding for malocclusion (Obswegeser technique) (P.A.)[3]	562.00

420.612: Fee Schedule of Hospital Services: Musculoskeletal System, Fractures

Service Code	Service Description	Allowable Fee
060907	Malar, simple or compound, depressed, open reduction	$224.50
060911	Zygoma, closed reduction	I.C.[4]
060912	open reduction	I.C.[4]

Service Code	Service Description	Allowable Fee
060913	Mid-facial, including orbital wall or floor, closed reduction	I.C.[4]
060914	Mid-facial, including orbital wall or floor, open reduction	I.C.[4]
060915	closed reduction, bilateral	I.C.[4]
060920	Maxilla, simple, no reduction	39.00
060921	with displacement, closed reduction	$112.50
060923	simple or compound, open reduction	337.00
060930	Mandible, no reduction	39.00
060931	closed reduction	168.00
060932	open reduction	I.C.[4]

420.613: Fee Schedule of Hospital Services: Musculoskeletal System, Joints

Service Code	Service Description	Allowable Fee
061241	Injection of TM joint for hypermobility (P.A.)[3]	I.C.[4]
061460	Temporomandibular dislocation	$ 22.00

420.614: Fee Schedule of Hospital Services: Respiratory System, Nose

Service Code	Service Description	Allowable Fee
	Repair	
062054	Closure of dental (oromaxillary) fistula with flap	$ 95.50
062055	Closure of dental (oromaxillary) fistula with flap and radical antrotomy	281.50

420.615: Fee Schedule of Hospital Services: Respiratory System, Accessory Sinuses

Service Code	Service Description	Allowable Fee
	Incision	
062084	Maxillary, sinusotomy, simple, antrum window, intranasal, unilateral	$112.50
062085	bilateral	I.C.[4]
062086	radical (Caldwell-Luc), unilateral (P.A.)[3]	281.50
062094	Removal of foreign body from maxillary sinus	I.C.[4]

420.616: Fee Schedule of Hospital Services: Digestive System, Mouth

Service Code	Service Description	Allowable Fee
	Incision	
062903	Biopsy of buccal mucosa	I.C.[4]
062905	Drainage of Ludwig's angina, inpatient	$224.50
062906	Excision of local lesion of buccal mucosa	I.C.[4]
062907	Excision of malignant lesion of buccal mucosa	I.C.[4]
062908	Excision of intraoral tumor, with jaw resection and radical neck dissection in continuity (P.A.)[3]	I.C.[4]
062909	Stomatoplasty, plastic or reconstruction on mouth (P.A.)[3]	I.C.[4]

420.617: Fee Schedule of Hospital Services: Digestive System, Lips

Service Code	Service Description	Allowable Fee
	Excision	
062911	Local excision of lesion of lips	$ 39.00
062915	V-excision of lesion of lips	67.00
062916	Resection of more than one-fourth lip (P.A.)[3]	224.50
062917	Resection of malignant lesion of lip, with primary closure (P.A.)[3]	I.C.[4]
	Repair (cheiloplasty)	
062927	Cheiloplasty, plastic or reconstruction operation on lip	I.C.[4]

420.618: Fee Schedule of Hospital Services: Digestive System, Tongue

Service Code	Service Description	Allowable Fee
	Incision (glossotomy)	
062933	Release of tongue tie, independent procedure	$ 17.00
	Excision (glossectomy)	
062940	Biopsy of tongue, independent procedure	30.50
062941	Local excision of lesion of tongue	45.00
062942	Glossorrhaphy: suture of tongue wound or injury	I.C.[4]
062943	Glossectomy, partial, less than one-half tongue (P.A.)[3]	168.00

Service Code	Procedure Description	Allowable Fee
	Excision	
062911	Local excision of lesion of lips	$ 35.00
062915	V-excision of lesion of lips	60.00
062916	Resection of more than one-fourth lip (P.A.) [3]	200.00
062917	Resection of malignant lesion of lip, with primary closure (P.A.) [3]	I.C. [4]
	Repair (cheiloplasty)	
062927	Cheiloplasty, plastic or reconstruction operation on lip	I.C. [4]

420.618: Fee Schedule of Hospital Services: Digestive System, Tongue

The following fee schedule lists the maximum allowable fees for these surgical services performed in a hospital.

Service Code	Procedure Description	Allowable Fee
	Incision (glossotomy)	
062933	Release of tongue tie, independent procedure	$ 15.00
	Excision (glossectomy)	
062940	Biopsy of tongue, independent procedure	27.00
062941	Local excision of lesion of tongue	40.00
062942	Glossorrhaphy: suture of tongue wound or injury	I.C. [4]
062943	Glossectomy, partial, less than one-half tongue (P.A.) [3]	150.00

420.619: Fee Schedule of Hospital Services: Digestive System, Teeth and Gums

The following fee schedule lists the maximum allowable fees for these surgical services performed in a hospital.

Service Code	Procedure Description	Allowable Fee
	Incision	
062960	Drainage of alveolar abscess, acute with cellulitis, oral approach, inpatient only	$ 65.00
062961	extraoral	I.C. [4]
062962	Drainage of dentigerous cyst, independent procedure	25.00
062963	Removal of tooth root from antrum	I.C. [4]
062964	Ridge extension (P.A.) [3]	I.C. [4]
062965	Cuspid exposure for orthodontic movement (P.A.) [3]	70.00
062966	Surgical movement of impacted tooth (P.A.) [3]	100.00
062967	Dental root resection: apicoectomy, one in conjunction with other surgery (P.A.) [3]	65.00
062968	more than one, individual procedure (P.A.) [3]	I.C. [4]
	Excision	
062969	Excision of incisive canal cyst	I.C. [4]
062970	Excision of adamantinoma (ameloblastoma)	I.C. [4]
062971	Partial bony impaction (P.A.) [3]	I.C. [4]
062972	each additional (P.A.) [3]	35.00
062973	Odontectomy, bony impaction with or without alveoplasty (P.A.) [3]	100.00
062974	each additional (P.A.) [3]	50.00
062975	Soft-tissue impaction (P.A.) [3]	35.00
062976	Subsequent soft-tissue impaction (P.A.) [3]	I.C. [4]
062977	Tooth extraction with or without alveoplasty, independent procedure except with odontectomy, one	10.00
062978	each additional ($100.00 maximum)	5.00
062979	Excision of cystic lesion of jaw	I.C. [4]
062980	Excision torus palatinus (P.A.) [3]	75.00
062981	Excision of mandibular tori (P.A.) [3]	50.00
062982	Excision of radicular cyst, involving area of one through four teeth	65.00
062983	involving area greater than four teeth	200.00
062984	Excision of dentigerous cyst or other benign lesion of jaw	I.C. [4]
062985	Excision of cystic hypertrophied tissue, edentulous ridge, independent procedure (P.A.) [3]	I.C. [4]

420.619: Fee Schedule of Hospital Services: Digestive System, Teeth and Gums

Service Code	Service Description	Allowable Fee
	Incision	
062960	Drainage of alveolar abscess, acute with cellulitis-oral approach, inpatient only	$ 73.50
062961	extraoral	I.C.[4]
062962	Drainage of dentigerous cyst, independent procedure	28.50
062963	Removal of tooth root from antrum	I.C.[4]
062964	Ridge extension (P.A.)[3]	I.C.[4]
062965	Cuspid exposure for orthodontic movement (P.A.)[3]	79.00
062966	Surgical movement of impacted tooth (P.A.)[3]	112.50
062967	Dental root resection: apicoectomy, one, in conjunction with other surgery (P.A.)[3]	73.50
062968	more than one, individual procedure (P.A.)[3]	I.C.[4]
	Excision	
062969	Excision, incisive canal cyst	I.C.[4]
062970	Excision, adamantinoma (ameloblastoma)	I.C.[4]
062971	Partial bony impaction (P.A.)[3]	I.C.[4]
062972	each additional (P.A.)[3]	39.00
062973	Odontectomy, bony impaction, with or without alveolectomy (P.A.)[3]	112.50
062974	subsequent (P.A.)[3]	56.50

Service Code	Service Description	Allowable Fee
062975	Soft-tissue impaction (P.A.)[3]	$ 39.00
062976	Subsequent soft-tissue impaction (P.A.)[3]	I.C.[4]
062977	Tooth extraction with or without alveolectomy (independent procedure except with odontectomy), one	11.50
062978	each additional	5.50
062979	Excision, cystic lesion of jaw	I.C.[4]
062980	Excision, torus palatinus (P.A.)[3]	84.00
062981	Excision, mandibular tori (P.A.)[3]	56.50
062982	Excision, radicular cyst, involving area of one through four teeth	73.50
062983	involving area greater than four teeth	224.50
062984	Excision, dentigerous cyst or other benign lesion of jaw	I.C.[4]
062985	Excision, cystic hypertrophied tissue, edentulous ridge, independent procedure (P.A.)[3]	I.C.[4]
062986	Gingivectomy, per quadrant, independent procedure (P.A.)[3]	39.00
	Suture	
062990	Suture of gum, independent procedure	28.50
062991	Excision, benign lesion of gum, independent procedure	39.00

Service Code	Service Description	Allowable Fee
062992	Excision, malignant lesion of gum or jaw	I.C.[4]
062993	Frenectomy, labial, independent procedure (P.A.)[3]	I.C.[4]
062994	Alveolectomy, with more than six extractions	$ 56.50
062995	Alveoplasty of edentulous mouth, one jaw (P.A.)[3]	112.50
062996	both jaws (P.A.)[3]	168.00
062997	Repair of accidental damage to teeth	I.C.[4]
062998	Vestibuloplasty, with skin graft for atrophic mandible (P.A.)[3]	I.C.[4]
062999	Repair of alveolar fracture, not including treatment of displaced or broken teeth	I.C.[4]

420.620: Fee Schedule of Hospital Services: Digestive System, Palate and Uvula

Service Code	Service Description	Allowable Fee
	Excision	
063010	Biopsy of palate, independent procedure	$ 33.50
063011	Resection of palate or wide excision of lesion of palate	I.C.[4]
063012	Excision of local lesion of palate (P.A.)[3]	56.50
	Repair	
063020	Repair of partial cleft palate (P.A.)[3]	506.00

420.621: Fee Schedule of Hospital Services: Digestive System, Salivary Glands and Ducts

Service Code	Service Description	Allowable Fee
	Incision	
063035	Sialolithotomy: removal of salivary calculus, intraoral, hospitalized	$ 28.50
	Excision	
063042	Excision, ranula	84.00
063047	Excision, submaxillary salivary gland and/or tumor	168.00
	Suture	
063070	Closure of salivary fistula	139.50
	Manipulation	
063080	Dilation of salivary duct, ptyalectasis, independent procedure	22.00

420.622: Fee Schedule of Hospital Services: Digestive System, Pharynx, Adenoids, and Tonsils

Service Code	Service Description	Allowable Fee
	Suture	
063127	Control of secondary oral or nasopharyngeal hemorrhage in hospital by operating surgeon	$ 28.50
063128	by consultant	73.50

Service Code	Procedure Description	Allowable Fee
	Incision	
063035	Sialolithotomy: removal of salivary calculus, intraoral, hospitalized	$ 25.00
	Excision	
063042	Excision of ranula	75.00
063047	Excision of submaxillary salivary gland and/or tumor	150.00
	Suture	
063070	Closure of salivary fistula	125.00
	Manipulation	
063080	Dilation of salivary duct, ptyalectasis, independent procedure	20.00

420.622: Fee Schedule of Hospital Services: Digestive System, Pharynx, Adenoids, and Tonsils

The following fee schedule lists the maximum allowable fees for these surgical services performed in a hospital.

Service Code	Procedure Description	Allowable Fee
	Suture	
063127	Control of secondary oral or nasapharyngeal hemorrhage in hospital, by operating surgeon	$ 25.00
063128	by consultant	65.00

420.623: Fee Schedule of Hospital Services: X Ray Diagnostic, Head and Neck

The following fee schedule lists the maximum allowable fees for these radiology services. These services are reimbursable only when performed in the office.

420.623: Fee Schedule of Hospital Services: X-Ray Diagnostics, Head and Neck

These services are reimbursable only when performed in the office.

Service Code	Service Description	Allowable Fee
067014	Mandible, unilateral, two views	$ 17.00
067015	bilateral, more than two views	20.00
067025	Facial bones, orbits, unilateral	22.00
067026	bilateral, minimum three views	33.50
067030	Nasal bones, three views minimum	17.00
067054	Skull, paranasal sinuses, or sella turcica, single view	11.50
067059	Skull or sella turcica, two through four views	28.50
067070	Temporomandibular joints, open and closed, unilateral	20.00
067071	bilateral	28.50

420.624: Fee Schedule of Hospital Services: Inpatient Visits

The fees apply to visits by dentists to hospitalized recipients or recipients who are admitted for hospitalization, except for routine preoperative and postoperative care to recipients who have undergone or who are expected to undergo surgery. (Allowable surgical fees include payment for routine preoperative and postoperative care.) Hospital visit fees are allowable only for care furnished to recipients who have undergone, or who are expected to undergo, surgery and only under exceptional circumstances and with a report.

Service Code	Service Description	Allowable Fee
069071	Initial hospital visit: a comprehensive history and physical examination, including initiation of diagnostic and treatment program and preparation of hospital records	$ 17.00

Service Code	Procedure Description	Allowable Fee
067014	Mandible, unilateral, two views	$ 15.00
067015	bilateral, more than two views	18.00
067025	Facial bones, orbits, unilateral	20.00
067026	bilateral, minimum three views	30.00
067030	Nasal bones, three views minimum	15.00
067054	Skull, paranasal sinuses, or sella turcica, single view	10.00
067059	Skull or sella turcica, two through four views	25.00
067070	Temporomandibular joints, open and closed, unilateral	18.00
067071	bilateral	25.00

420.624: Fee Schedule of Hospital Services: Inpatient Visits

The following fee schedule lists the maximum allowable fees for hospital inpatient visits. The fees apply to visits by dentists to hospitalized recipients or recipients who are admitted for hospitalization, except for routine preoperative and postoperative care to recipients who have undergone or who are expected to undergo surgery. (Allowable surgical fees include payment for routine preoperative and postoperative care.) Hospital visit fees are allowable only for care furnished to recipients who have undergone, or who are expected to undergo, surgery and only under exceptional circumstances and with a report.

Service Code	Procedure Description	Allowable Fee
069071	Initial hospital visit: comprehensive history and physical examination, including initiation of diagnostic and treatment program and preparation of hospital records	$ 15.00
069074	Limited examination, evaluation, and treatment: subsequent or follow-up visit	8.00
069082	Concomitant medical care	I.C. [4]

420.625: Fee Schedule of Hospital Services: Consultations

The following fee schedule lists the maximum allowable fees for hospital consultations.

Service Code	Service Description	Allowable Fee
069074	Limited examination, evaluation, and treatment: subsequent or follow-up visit	$ 9.50
069082	Concomitant medical care	I.C.[4]

420.625: Fee Schedule of Hospital Services: Consultations

Service Code	Service Description	Allowable Fee
069150	Limited consultation: requiring limited or more extensive examination and/or evaluation but not requiring a comprehensive history and examination	$ 16.00
069151	Extended consultation: requiring comprehensive history and examination and/or evaluation (with report only)	26.50
069153	Consultation of unusual complexity: in excess of scope of services identified by Service Code 069151; necessitating history and examination, extensive review of prior medical records as indicated, compilation and assessment of data, and preparation of special report (with report only)	37.00

420.626: Fee Schedule of Hospital Services: Unlisted Procedures

Service Code	Service Description	Allowable Fee
069299	Unlisted procedure (with report only) (P.A. if elective)[3]	I.C.[4]

REGULATORY AUTHORITY

106 CMR 420.000: M.G.L. c. 18, s. 10; M.G.L. c. 118E, s. 4.

Service Code	Procedure Description	Allowable Fee
069150	Limited consultation: requiring limited or more extensive examination and/or evaluation but not requiring a comprehensive history and examination	$ 12.00
069151	Extended consultation: requiring comprehensive history and examination and/or evaluation (with report only)	20.00
069153	Consultation of unusual complexity (in excess of scope of services identified by Service Code 069151): necessitating history and examination, extensive review of prior medical records as indicated, compilation and assessment of data, and preparation of special report (with report only)	30.00

420.626: Fee Schedule of Hospital Services: Unlisted Procedures

The following service code is to be used when the hospital procedure is not listed.

Service Code	Procedure Description	Allowable Fee
069299	Unlisted procedure (with report only) (P.A. if elective) 3	I.C. 4

REGULATORY AUTHORITY

106 CMR 420.000: M.G.L. c. 18, s. 10; M.G.L. c. 118E, s. 4.

106 CMR is amended by repealing 106 CMR 477.000: Conditions of Participation--Guidelines for Family Planning Services, and 106 CMR 478.000: Family Planning Services, and adding the following chapter:

106 CMR 421.000: MEDICAL ASSISTANCE PROGRAM: FAMILY PLANNING AGENCY SERVICES

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(106 CMR 421.001 through 421.400 Reserved)

421.401: Introduction

Family planning services are those medical, educational, and social services that assist individuals of childbearing age, including sexually active minors, in determining the number and spacing of their children. The regulations in this Chapter 421.000 govern family planning services furnished by those family planning agencies certified by the Department to participate in the Medical Assistance Program.

421.402: Eligible Recipients

(A) Medical Assistance Recipients. The family planning agency services described in these regulations are reimbursable for all Medical Assistance recipients (categories of assistance 00, 01, 02, 03, 05, 06, 07, and 08).

(B) General Relief Recipients. The family planning agency services described in these regulations are not reimbursable for General Relief recipients (category of assistance 04). The Department will pay for family planning services for General Relief recipients only when provided by a physician in the physician's office.

421.403: Provider Eligibility

Payment for the services described in this Chapter 421.000 will be made only to family planning agencies that are participating in the Medical Assistance Program as of the date of service. The eligibility requirements for family planning agencies are as follows.

(A) In State.

(1) A family planning agency located in Massachusetts is eligible to participate in the Medical Assistance Program only if it is certified by the Department as a family planning agency, in accordance with the requirements spec-

ified in Sections 421.404 through 421.427.

(2) The family planning agency must fulfill one of the following licensing requirements.

(a) Family planning services must be provided in a facility licensed as a clinic or hospital by the Massachusetts Department of Public Health.

(b) Family planning services must be provided under the license of a physician licensed by the Massachusetts Board of Registration in Medicine.

(3) A family planning agency may provide family planning services in one or more service delivery sites, which must be located in free-standing clinics, community health centers, hospital outpatient departments, or hospital-licensed health centers.

(B) Out of State. A family planning agency located outside of Massachusetts is eligible to participate in the Massachusetts Medical Assistance Program only if it meets the licensing requirements in its state, participates in that state's Medical Assistance Program (or equivalent), and meets the requirements specified in Sections 421.404 through 421.427.

421.404: Staffing

(A) Personnel Policies.

(1) Current job descriptions must be available for all positions on the staff.

(2) Written personnel policies must be available to all personnel.

(3) An evaluation and review of the job performance of all personnel must be conducted annually.

(B) Personnel Qualifications and Responsibilities.

(1) Administrator. A family planning agency must employ a full-time administrator who is responsible for supervising family planning services and for managing the family planning agency. The administrator must have demonstrated experience in the area of health-care administration.

(2) Medical Director. A family planning agency must employ a medical director who is a physician licensed by the Massachusetts Board of Registration in Medicine and who has demonstrated familiarity with gynecological examination and contraceptive prescription. The medical director is responsible for coordinating medical-staff activities as well as the medical aspects of the family planning program. The medical director assumes responsibility for the implementation of family planning protocol (see Subsection

421.412(E)); the maintenance of clinic standards; and the credentials review, training, and supervision of all staff physicians, nurse practitioners, and other medical personnel.

(3) Physician. A physician who is licensed by the Massachusetts Board of Registration in Medicine and who has demonstrated familiarity with gynecological examination and contraceptive prescription may provide medical care and medical supervision in a family planning agency. A physician must be either on site or on call during all clinic sessions.

(4) Nurse Practitioner. A nurse practitioner who is licensed by the Massachusetts Board of Registration in Nursing may work in a family planning agency under the supervision of a physician. A nurse practitioner must comply with all conditions of licensure including all statutory and regulatory provisions governing nurse-practitioner practice. On the basis of the nurse practitioner's education, experience, and clinical skills, the medical director must define and must re-evaluate annually the nurse practitioner's responsibilities.

(5) Physician Assistant. A physician assistant who is a graduate of a program approved by the Massachusetts Board of Approval and Certification of Physician Assistant Programs may work in a family planning agency under the supervision of a physician. A physician assistant must comply with all statutory and regulatory provisions governing physician-assistant practice. On the basis of the physician assistant's education, experience, and clinical skills, the supervising physician must define and must re-evaluate annually the physician assistant's responsibilities.

(6) Nurse. A nurse who is licensed by the Massachusetts Board of Registration in Nursing as a registered nurse or a licensed practical nurse may assist the physician, take medical histories, and conduct patient education and instruction about contraception in a family planning agency.

(7) Counselor or Outreach Worker. A counselor or outreach worker who has studied human anatomy and physiology, human reproduction, contraceptive methods, and counseling techniques may provide patient education, counseling, follow-up, and community education for a family planning agency.

(C) Inservice Training. Family planning agency personnel must participate in continuing education programs related to their activities, including orientation, on-the-job training, and regular inservice training.

(106 CMR 421.405 through 421.410 Reserved)

421.411: Certification

The Department will certify the following two types of family planning agencies:

(A) comprehensive family planning agencies that provide five components of service: medical and laboratory, counseling, follow-up and referral, community education, and outreach; and

(B) medical and counseling family planning agencies that provide three components of service: medical and laboratory, counseling, and follow-up and referral.

421.412: Medical and Laboratory Services

(A) For an initial or annual visit, a family planning agency must provide all of the following medical and laboratory services:

(1) a complete medical history (including family and interval);

(2) a physical examination:

(a) for a female recipient, this includes thyroid, breast, heart, abdominal, speculum, pelvic, and rectal examinations, and measurements of height, weight, and blood pressure;

(b) for a male recipient, this includes thyroid, heart, genital, abdominal, and rectal examinations, and measurements of height, weight, and blood pressure;

(3) a Pap smear (for a female recipient);

(4) any laboratory test indicated by the recipient's history or examination (such a test may be provided directly or by referral);

(5) a medically approved method of contraception, if appropriate; and

(6) referrals for the screening, diagnosis, prevention, or treatment of general as well as reproductive medical conditions.

(B) For a routine visit, a family planning agency must provide medical and laboratory services necessary to monitor the recipient's contraceptive care or to follow up on conditions requiring medical attention by agency personnel. These services must include, but are not limited to, the following:

(1) update of medical history;

(2) a physical examination that includes pelvic or genital examination;
(3) measurements of blood pressure and weight;
(4) any laboratory test indicated by the recipient's history or examination (such a test may be provided directly or by referral);
(5) identification of any symptoms, conditions, or side effects that may contraindicate the method of contraception used;
(6) assessment of the recipient's use of the method of contraception; and
(7) referrals for the screening, diagnosis, prevention, or treatment of general as well as reproductive medical conditions.

(C) A family planning agency must make available all methods of contraception.

(D) Physical examinations must be performed by a physician, a nurse practitioner, or a physician assistant. A physician must examine all recipients with medical problems and recipients who request to be seen by a physician. A nurse practitioner or physician assistant may examine recipients during an initial, annual, or routine visit. However, the family planning agency must ensure that a recipient who is a regular patient is examined by a staff physician at least once every two years. A physician must be on site or on call during all clinic sessions.

(E) The family planning agency must have written medical protocols that include a periodicity schedule for return visits, procedures for follow-up for each method of contraception, procedures for care of high-risk patients, and emergency drug protocols.

421.413: Counseling

A family planning agency must provide counseling to assist recipients in achieving their family planning goals. Such counseling may include discussing general health, human anatomy, physiology, reproduction, and all available methods of contraception. Specific information about the safety of a method (potential side effects or complications), its effectiveness, its acceptability to recipient and partner, and its correct usage must be given. Surgical procedures must be discussed if the recipient prefers a permanent method of contraception. Follow-up counseling may include reinforcement of contraceptive instructions and reproductive information, discussion of recipient concerns or problems, and additional education.

421.414: Follow-Up and Referral

(A) Follow-Up. The family planning agency must have a system of contacting recipients who are patients of that family planning agency to remind them of their annual visits.

(B) Referral.

(1) A family planning agency must have arrangements with medical, social-service, and other community-service agencies to which appropriate referrals may be made for recipient problems identified during a family planning visit. The family planning agency must make referrals for necessary services if those services are not available on site. These services include, but are not limited to, the following:

(a) treatment of medical problems beyond the scope of the family planning agency;

(b) follow-up on positive results of tests for venereal disease or on other laboratory tests;

(c) pregnancy-related services;

(d) infertility evaluation, treatment, and counseling;

(e) genetic counseling;

(f) sterilization services or information; and

(g) social case work beyond the scope of the family planning agency.

(2) All referrals must include follow-up to ensure that the referral process is completed successfully. If the referral was for an abnormal laboratory test result or a reproductive health problem, follow-up must include arrangements for receiving written results of tests or a report of initiated treatment.

421.415: Community Education

(A) A comprehensive family planning agency must provide community education. The objectives of a community education program include, but are not limited to, the following:

(1) promoting community awareness and support of family planning services;

(2) providing information about family planning or reproduction to interested groups or individuals;

(3) integrating family planning education into educational institutions and community organizations; and

(4) being a resource for other professionals in family planning education.

(B) A community education program must attempt to address the objectives in Subsection (A) above through methods that are appropriate to the needs of the community. Such methods must

include at least two of the following:
(1) educational programs for adolescents, parents, professionals, and other targeted groups;
(2) consultations with community organizations, schools, or church groups;
(3) workshops or conferences;
(4) health fairs;
(5) speaking engagements;
(6) media activities (for example, television or radio talk shows and newspaper articles);
(7) participation in curriculum development and implementation; or
(8) development of educational materials.

421.416: Outreach

(A) A comprehensive family planning agency must perform outreach activities. The objectives of an outreach program include, but are not limited to, the following:
(1) to make known to an entire community the availability of family planning services;
(2) to encourage use of the agency's services by certain populations, such as adolescents and persons eligible for Medical Assistance, that are not currently receiving services adequate to meet their needs; and
(3) to build linkages and referrals with local agencies and professionals.

(B) An outreach program must attempt to address the objectives in Subsection (A) above through methods that are appropriate to the needs of the community. Any of the methods for providing community education that are listed in Subsection 421.415(B) may also be used for outreach. In addition, outreach methods must include one or more of the following:
(1) publications for distribution;
(2) advertisements;
(3) public-service announcements and media spots;
(4) information disseminated to groups and individuals in the target populations and, to the extent possible, in the native language and in the locality of the populations;
(5) contact and information exchange with local Welfare Service Offices; and
(6) establishment of referral agreements with local agencies and professionals.

(106 CMR 421.417 through 421.420 Reserved)

421.421: Coordination of Services

When a family planning agency is located in a community health center, a hospital, or another primary-care setting, the agency must demonstrate that family planning services are coordinated with and integrated into other services delivered on site. Such coordination includes at a minimum:

(A) either one central medical record for each recipient in which all medical and health-care services are recorded, or a mechanism for transferring relevant information to medical records to ensure continuity of care;

(B) avoidance of duplication of medical examinations and laboratory tests; and

(C) in-house referrals, as appropriate.

421.422: Emergency Backup

A family planning agency must have provisions for 24-hour emergency backup. Each recipient must be given the emergency telephone number in writing at the time of initiation of services. The telephone number must also be displayed prominently in the family planning agency.

421.423: Recordkeeping Requirements

(A) Payment for any service listed in this Chapter 421.000 is conditioned upon its full and complete documentation in the recipient's medical record. A family planning agency must maintain a record of all medical and contraceptive services furnished to a recipient for at least four years following the date of service. Every recipient visit or telephone call with the staff must be recorded. The documentation must include the reason for each visit or telephone call and any action taken.

(B) The medical record must contain, but is not limited to, the following information:

(1) the recipient's name, address, telephone number, date of birth, and Medicaid identification number;
(2) the date of service;
(3) the name, title, and signature of the person performing the service or making the contact;
(4) the type of visit (for example, annual or routine);
(5) medical history and history update;
(6) pertinent findings on examination;
(7) laboratory tests and results;

(8) abnormal findings and follow-up treatment;
(9) drugs administered or prescribed, including strength, dosage, route, regimen, and number of refills;
(10) drugs dispensed, including strength, dosage, route, regimen, and number of units;
(11) the contraceptive method used and any special instructions;
(12) a summary of counseling; and
(13) plans for follow-up.

(C) Basic information collected during previous visits with the recipient (for example, identifying data or medical history) need not be repeated in the medical record for subsequent visits as long as the entire medical record reflects continuity of care.

421.424: Quality Assurance

(A) Medical.
(1) The medical director or his designee must perform an on-site review of all physicians, nurse practitioners, and physician assistants within the first three months of their employment and thereafter annually for physicians and semi-annually for nurse practitioners and physician assistants. Written reports of these reviews must be included in the personnel file. The on-site review must include observation and assessment of the clinical skills of the practitioner in caring for a variety of patients.
(2) The medical director or his designee must review at least four times a year a sample of the agency's records for adequacy of documentation and appropriateness of treatment and follow-up.

(B) General. A family planning agency must have on-going evaluation processes and appropriate plans of action for all program activities (including counseling and outreach services), clinic management, and availability of services.

421.425: Reporting Requirements

At the beginning of each quarter of the Department's fiscal year (July 1 of a calendar year through June 30 of the following calendar year), all comprehensive family planning agencies must submit a report of the previous quarter's education and outreach activities. The format and content of the report are specified in Appendix E of the Family Planning Agency Manual. The reports must be submitted to the Department no later than October 15 for the first quarter of the fiscal year, January 15 for the second quarter, April 15 for the third quarter, and July 15 for the fourth quarter.

421.426: Consumer Participation

A family planning agency must be responsive to its consumers' needs and desires. To this end, a family planning agency must have at least one consumer on its board or a consumer advisory group. Consumer representatives may not be employed by the agency while they are members of the board or group. Matters subject to review by the board or group must include, but are not limited to, policy development, service delivery, and program evaluation.

421.427: Assurance of Recipient Rights

(A) Services must be made available to all recipients who request services, without regard to race, color, national origin, religion, creed, age, sex, parity, marital status, or handicap.

(B) A recipient's use of family planning services must be completely voluntary. No provider shall coerce recipients in any way to receive services or to employ any particular method of family planning. Neither the Department nor any provider, nor any agent or employee of a provider, shall mislead any recipient into believing that a decision to accept or not to accept family planning services will adversely affect his entitlement to benefits or services.

(C) The design of the agency's facilities must ensure privacy, confidentiality, and regard for the dignity of the recipient during personal interviews, consultations, medical examinations, and treatment. All information disclosed to agency personnel by the recipient or found as a result of the recipient's examination, care, and treatment must be held in strict confidentiality.

(106 CMR 421.428 through 421.430 Reserved)

421.431: Maximum Allowable Fees

The Massachusetts Rate Setting Commission determines the maximum allowable fees for family planning agency services. Payment is always subject to the conditions, exclusions, and limitations set forth in these regulations. The payment for a service shall be the lower of the following:

(A) the amount specified in the applicable fee schedule; or

(B) the agency's usual and customary fee (if the agency uses a sliding fee scale, this is the highest level of the scale).

421.432: Payment: Visits

(A) The payment for a family planning visit depends upon the type of certification (comprehensive family planning agency or medical and counseling family planning agency) granted by the Department.

(B) The payment for a family planning visit includes payment for the administrative operation of the family planning agency and for all aspects of service delivery, excluding laboratory tests, supplies, and drugs. Other than payment for laboratory tests, supplies, and drugs, no additional fees will be paid by the Department.

(C) For each recipient encounter, the Department will pay for only one of the following types of visits.

(1) Comprehensive Visit. The Department will pay for a comprehensive visit only when the encounter is an initial, annual, or extended visit. An initial or annual visit must include all of the medical, laboratory, and counseling services required in Subsection 421.412(A) and Section 421.413. The Department will pay for only one initial or annual visit per recipient per year. An encounter is considered to be an extended visit when it is not routine in nature because extensive medical attention is necessary. Such a visit must last approximately 30 minutes. For an extended visit, the need for such services and the time elapsed must be documented in the medical record by the physician.

(2) Routine Visit. The Department will pay for a routine visit when the encounter is a return, follow-up, or other visit that is not comprehensive and during which medical services are performed by a physician, nurse practitioner, or physician assistant. A routine visit must include all of the medical, laboratory, and counseling services required in Subsection 421.412(B) and Section 421.413.

(3) Minimal Service Visit. The Department will pay for a minimal service visit when the encounter is a return visit consisting of counseling services only, or of a brief medical encounter and counseling services. The purpose of a minimal service visit is to reinforce contraceptive instructions, to monitor the recipient's use of a contraceptive method, or to provide education and counseling.

(D) The Department will not pay for a visit whose sole purpose is to replenish a recipient's supply of contraceptives. In this case, only the cost of the contraceptive supplies is reimbursable.

421.433: Payment: Laboratory Services

(A) Reimbursable Services. The Department will pay a family planning agency for laboratory services that are performed either at the agency or at an outside laboratory as a result of specimen referral. For tests performed at an outside laboratory, the Department will pay according to the laboratory's charge to the agency or the laboratory fee schedule amount, whichever amount is less.

(B) Nonreimbursable Services. The Department will not pay a family planning agency for routine specimen collection and preparation for the purpose of clinical laboratory analysis (for example, venipunctures; urine, fecal, and sputum samples; Pap smears; cultures; and swabbing and scraping for removal of tissue); or such calculations as red blood cell indices, A/G ratio, creatinine clearance, and those ratios calculated as part of a profile.

(C) Profile or Panel Tests.

(1) A profile or panel test is defined as any group of tests, whether performed manually, automatedly, or semiautomatedly, which is ordered for a specified recipient on a specified day and has at least one of the following characteristics.

(a) The group of tests is designated as a profile or panel by the family planning agency performing the tests.

(b) The group of tests is one of the "other profiles" in Subsection 421.604(B).

(c) The group of tests contains three or more tests from List A in Subsection 421.604(B), even though the group may also contain tests not found in List A.

(d) The group of tests is performed by the agency at a usual and customary fee that is lower than the sum of that agency's usual and customary fees for the individual tests in that group.

(2) In no event shall a family planning agency bill or be paid separately for each of the tests included in a profile test when a profile test has either been performed by that agency or requested by an authorized person.

(D) Individual Consideration. Some services listed in the fee schedule are designated "I.C.", an abbreviation for individual consideration. This means that a specific fee could not be established. The payment for an I.C. service will be determined by the Department's professional advisors based on the name of the test entered on the claim form.

421.434: Payment: Contraceptive Supplies and Drugs

(A) Contraceptive Supplies. The Department will pay for contraceptive supplies according to the fee schedule in Section 421.603. If the family planning agency purchases supplies at a price lower than that allowed in the fee schedule, the agency must bill the Department at that lower price.

(B) Drugs. The Department will pay for drugs at the actual acquisition cost not to exceed the average wholesale price listed in the current edition of or supplements to the Drug Topics Red Book. Claims for dispensing drugs must include the following information: the name of the drug; the strength; the dosage; and the number of units. Claims without this information will be denied. Payment for drugs shall be determined on an individual consideration (I.C.) basis by the Department, based on the information entered on the claim form.

(106 CMR 421.435 through 421.440 Reserved)

421.441: Project Good Health Services: Family Planning Agency Participation

(A) The Department will pay a family planning agency for providing the Project Good Health (PGH) services described in Sections 421.442 through 421.452 to a recipient only when the primary purpose of the recipient's visit is to obtain comprehensive family planning services. The PGH Medical Protocol and Periodicity Schedule includes age groups younger than the customary family planning agency clientele but is reproduced in its entirety in Section 421.445 for the agency's reference.

(B) PGH services must be provided in compliance with Sections 421.442 through 421.452. Medical services must include all of the requirements for both a comprehensive family planning visit (see Subsection 421.432(C)(1)) and a PGH health assessment (see Section 421.446). However, the family planning agency shall not duplicate required services. When billing for a comprehensive visit with PGH services, the agency must use the appropriate PGH service code (see Subsection 421.449(D)) instead of a service code listed in Section 421.601 or 421.602.

421.442: Project Good Health Services: Introduction

(A) Legal Basis. Federal law governing Medical Assistance Programs requires the establishment of a program of Early and Periodic Screening, Diagnosis and Treatment (EPSDT) for per-

sons under the age of 21 who are eligible for Medical Assistance (see 42 U.S.C. 1396d(a)(4)(b) and 42 CFR 441.50). Project Good Health (PGH) is the name given to the EPSDT program established in Massachusetts. The Department pays for PGH services provided to Medical Assistance recipients who are under the age of 21, including those who are parents. Sections 421.442 through 421.452 establish the regulations governing family planning agencies that provide PGH services.

(B) Program Objectives. The objectives of PGH are:
(1) to provide to eligible persons comprehensive and continuous health care designed to prevent illness and disability;
(2) to ensure early detection and prompt treatment of health problems before they become chronic or cause irreversible damage; and
(3) to create an awareness of the availability and value of preventive health-care services.

421.443: Project Good Health Services: Definitions

The following definitions apply to PGH services.

(A) Health Assessment -- the provision of screening procedures appropriate to the recipient's age and medical history, as indicated by the Medical Protocol and Periodicity Schedule.

(B) Medical Protocol and Periodicity Schedule -- a schedule (see Section 421.445) developed by the Department in consultation with the Massachusetts Chapter of the American Academy of Pediatrics that consists of screening procedures arranged according to the intervals or age levels at which each procedure is to be carried out. Any deviation from the Medical Protocol and Periodicity Schedule must be documented according to Subsection 421.446(B).

(C) PGH Referral -- a recommendation by the screening family planning agency to a PGH recipient that the recipient return to the screening agency or see another provider for any additional test, diagnosis, or treatment indicated by the screening. The transmission of a specimen to a laboratory does not constitute a referral.

421.444: Project Good Health Services: Provider Cooperation with PGH Specialists

(A) PGH Specialists. PGH specialists are employees of the Department who inform recipients and providers about PGH, assist recipients in scheduling and keeping appointments for

health assessments and for further diagnosis and treatment, and follow up to ensure that services have been received.

(B) Provider Cooperation.

(1) Federal law mandates that recipients who have requested assistance in obtaining medical care from the Department or a screening provider receive health assessments, diagnosis, and treatment within defined time periods. To ensure the Department's compliance with these time limits, the PGH specialist must follow up all health assessments the Department has arranged for by obtaining the information listed in Subsections (1)(a) through (c) below. A family planning agency must furnish the following information concerning each claim for PGH services if requested by the PGH specialist in its area:

(a) whether the health-assessment appointment was kept;

(b) whether a referral was made for further diagnosis and treatment; and

(c) if known, the date of the referral appointment.

(2) Once a family planning agency has submitted a claim for PGH services, the agency must furnish health assessments for all recipients referred to it by the Department until that agency notifies the Department's Medical Division in writing that it no longer intends to provide PGH services.

(C) Disclosure Requirement. Recipients must be informed by the family planning agency that information about their medical care will be furnished to the Department.

421.445: Project Good Health Services: Medical Protocol and Periodicity Schedule

Payment for PGH services is based upon the performance and documentation of the procedures listed in the Medical Protocol and Periodicity Schedule herein. The Schedule provides for basic preventive care and identifies recipients who require further diagnosis of suspected or actual health problems, treatment, or both. Explanations of procedures that appear in the Schedule and the information that must be maintained in the medical record to substantiate the performance of such procedures appear below.

(A) (Newborn) Initial History and Physical Examination -- documenting either in the agency's medical record or in the hospital chart an examination of the newborn.

(B) (Newborn) Discharge History and Physical Examination -- documenting either in the agency's medical record or in the hospital chart the discharge history and physical examination of the newborn.

(C) Health History -- recording in the medical record the family health history, baseline data on the recipient if not recorded previously, growth and development history, known reactions to medications and allergies, and pertinent information about previous illnesses, hospitalizations, and other medical and psychosocial problems.

(D) Interval History -- updating previously collected health history in the medical record with any illnesses, diseases, or medical problems experienced by the recipient since his last visit.

(E) Comprehensive Physical Examination -- documenting the findings of an unclothed physical examination including a complete systems review pertinent to the age of the recipient, fundoscopic examination of the eyes for recipients over five years of age, and observation of the teeth and gums for recipients three years of age or older.

(F) Developmental Assessment -- the combined observations by the recipient's parent or guardian and by the agency of the recipient's current levels of functioning in the following areas, as appropriate to the recipient's age:

(1) gross motor development, including strength, balance, and locomotion;
(2) fine motor development, including eye-hand coordination;
(3) language development, including expression, comprehension, and articulation;
(4) self-help and self-care skills;
(5) social interaction and emotional development; and
(6) cognitive skills, including problem-solving and reasoning abilities.

(G) Nutritional Status Assessment -- the evaluation of the recipient's nutritional health in light of dietary practice and the entire health assessment (that is, history, physical examination, height and weight measurements, and laboratory tests) and documentation of any nutritional disturbance or dysfunction.

(H) Appropriate Immunizations -- the administration of injections and serums in accordance with the recommendations of the Massachusetts Department of Public Health and the American Academy of Pediatrics.

(I) Gross Hearing and Vision Tests -- the combined observations by the recipient's parent or guardian and by the agency of the recipient's response to sound and ability to follow moving objects visually.

(J) Blood Pressure -- a standard procedure of the physical examination for recipients three years of age or older.

(K) Hearing Test (Audiometer) -- audiometric testing at the following frequencies: 500 Hz, 1000 Hz, 2000 Hz, and 4000 Hz.

(L) Vision Test -- testing by the Snellen chart, Titmus machine, or equivalent.

(M) PGH Education and Counseling -- educating and counseling the recipient, or his parent or guardian, in matters appropriate to the recipient's age (for example, nutrition, growth and development, tobacco, drugs, and sexuality).

(N) Assessment of Mental and Emotional Health -- the collaboration by the agency, the recipient's parent or guardian, and the recipient in evaluating the recipient with respect to the following:

(1) the potential presence of learning disabilities;
(2) peer relations; and
(3) problems, especially depression, in psychological and psychiatric areas.

(O) Pelvic Examination -- documenting the general and specific condition of genitalia and internal reproductive organs. Documentation includes both normal and abnormal findings for the initial pelvic examination and any abnormalities found thereafter.

(P) EP -- the erythrocyte protoporphyrin method of testing for lead poisoning and iron deficiency.

MEDICAL PROTOCOL AND PERIODICITY SCHEDULE

SCREENING PROCEDURES	RECOMMENDED AGE: New-born	2-6 wks	8-10 wks	4 mos	6 mos	9 mos	1 yr	15 mos	20 mos	2 yrs	30 mos	3 yrs	4 yrs	5 yrs	6 yrs	7 yrs	8 yrs	9 yrs	10-11 yrs	12-13 yrs	14-15 yrs	16-17 yrs	18-19 yrs	20 yrs
Initial history and physical examination	1																							
Discharge history and physical examination	1																							
Health history		2	2	2	2	2	2	2	2	2	2	2	2	2	2	2	2	2	2	2	2	2	2	
Interval history			1	1	1	1	1	1	1	1	1	1	1	1	1	1	1	1	1	1	1	1	1	1
Comprehensive physical exam		1	1	1	1	1	1	1	1	1	1	1	1	1	1	1	1	1	1	1	1	1	1	1
Developmental assessment		1	1	1	1	1	1	1	1	1	1	1	1	1	1	1	1	1	1	1	1	1	1	1
Nutritional status assessment		1	1	1	1	1	1	1	1	1	1	1	1	1	1	1	1	1	1	1	1	1	1	1
Appropriate immunizations		1	1	1	1	1	1	1	1	1	1	1	1	1	1	1	1	1	1	1	1	1	1	1
Hearing/vision tests (gross)		1	1	1	1	1	1	1	1	1	1	1	1	1	1	1	1	1	1	1	1	1	1	1
Blood pressure												1	1	1	1	1	1	1	1	1	1	1	1	1
Hearing test (audiometer)															4				4					4
Vision test														1		3				3				5
Full education and counseling	10	10	10	10	10	10	10	10	10	10	10	10	10	10	10	10	10	10	10	10	10	10	10	10
Mental and emotional health status assessment																			1	1	1	1	1	1
Pelvic examination																					9	9	1	1
Hematocrit or hemoglobin							2	1																
EP or blood lead							1	6		3		6		3										
TB test							1								4						3			
Urinalysis and/or culture (if indicated)													1	3	1			1	1	1	1	1	1	1
Cholesterol-if history indicates											1													
Sickle cell test																				7				
Pap smear																					8	8	1	1
GC culture																					9	9	1	1
Serology																					9	9	9	9

Legend

1. The procedure must be done at this age.
2. The procedure must be done if not done previously.
3. The procedure must be done if not done during the last examination age on the schedule.
4. The procedure must be done if not done during the last two examination ages on the schedule.
5. The procedure must be done if not done during the last three examination ages on the schedule.
6. The EP or blood lead test should be performed if the child lives in a city that has a population over 100,000 and if medically necessary.
7. This procedure should be performed only once and only if indicated by ethnicity.
8. This procedure must be performed if a pelvic examination is performed at this visit.
9. This procedure is optional depending on the maturity level and sexual activity of the recipient.
10. This procedure should be done if appropriate.

421.446: Project Good Health Services: Description of Health Assessments

The health assessments described in this section are reimbursable when provided by a physician or by a nurse practitioner or physician assistant under a physician's supervision.

(A) PGH Health Assessment. A family planning agency may claim payment using Service Code 160041 or 160042 for a PGH health assessment only if all the screening procedures in the Medical Protocol and Periodicity Schedule that correspond to the recipient's age have been performed. While the screening procedures are based upon a presumption of regular contact with health-care providers, many recipients have infrequent attention paid to their health-care needs and will need additional screening procedures to bring them up to date. In such a case, it is the agency's responsibility to furnish those additional screening procedures necessary to bring the recipient up to date with his preventive health care according to the Medical Protocol and Periodicity Schedule. The agency may make a screening referral to another provider if the agency is unequipped to perform a test (for example, if the agency does not have an audiometer and an audiometric test is required). However, in every case, all required screening procedures must have been performed and all results received in order for the agency to claim payment for a PGH health assessment.

(B) PGH Health Assessment with Special Circumstances. A family planning agency may claim payment using Service Code 160043 or 160044 for a PGH health assessment with special circumstances only in the following situations: a screening procedure has been omitted from the health assessment; or the results of laboratory tests or other referred screening procedures were not available within 30 days (see Subsections (1) and (2) below). The Department will review individually all claims for PGH health assessments with special circumstances to determine whether payment will be made. All claims for such health assessments based on the omission of a medically unnecessary screening procedure will be reviewed by a physician.

(1) Omission of a Procedure. An agency may omit a procedure from a health assessment only in the following situations.

(a) Procedure Was Not Medically Necessary. If the person performing the health assessment omitted a screening procedure from a PGH health assessment because, in his professional judgment, the procedure was not medically necessary, the agency must include with the claim for

payment a statement citing the omitted procedure and the reason that it was not medically necessary. If the procedure was omitted because it was performed earlier, the date of such procedure must be included in the statement. For the purposes of this subsection, nonperformance of a procedure in the Medical Protocol and Periodicity Schedule that has the legend number 6, 7, 8, 9, or 10 corresponding to the recipient's age is not considered to be an omission, since such nonperformance is based upon factual determination rather than medical judgment.

(b) Procedure Was Impossible to Perform. If the person performing the health assessment omitted a screening procedure from a PGH health assessment because it was impossible to perform, the agency must include with the claim for payment a statement citing the omitted procedure and the reason that the procedure was impossible to perform. If the procedure was impossible to perform because the recipient refused to cooperate, the agency must describe in the statement its efforts to overcome the problem.

(2) Results of Referred Screening Procedure Not Available within 30 Days. If an agency did not know the results of a laboratory test or other referred screening procedure within 30 days after the health assessment, the agency must include with the claim for payment a statement that the laboratory or other provider has not returned the results and citing which results are outstanding.

421.447: Project Good Health Services: Dental Care

The screening family planning agency must encourage the recipient to seek regular dental care, including annual examinations, preventive services, and treatment as necessary, from a dental provider. The Department will inform recipients three years of age or older, or their parents or guardians, about available dental care and will offer assistance in scheduling and keeping appointments with dental providers.

421.448: Project Good Health Services: Diagnosis and Treatment

(A) For any problem that requires further diagnosis or treatment after the health assessment, the family planning agency either must request that the recipient return for another appointment or must refer the recipient to another provider. Federal regulation mandates the time limits within which screening, diagnosis, and treatment must be performed. Therefore, the request or the referral must be made immediately or as soon as the agency obtains the screening result indicating a need for referral.

(B) When making a referral to another provider, the screening agency must give to the recipient or to the recipient's parent or guardian the name and address of an appropriate provider.

(C) The screening agency must establish a procedure to obtain a report of the results of diagnosis and treatment.

(D) If an agency knows of any reason that a recipient might not make or keep an appointment for further diagnosis and treatment, such as a need for transportation, translation, or child care, the agency must contact the PGH specialist in its area for assistance. For a list of locations and telephone numbers of PGH specialists, see Appendix D of the Family Planning Agency Manual.

421.449: Project Good Health Services: Claims for Health Assessments

(A) Fees for Health Assessments. The fee schedule in Subsection (D) below was adopted by the Massachusetts Rate Setting Commission for PGH health assessments furnished in accordance with the Medical Protocol and Periodicity Schedule and with these PGH regulations.

(B) Service Limitations. For each recipient from birth through nine years of age, an agency may claim only one health assessment per age level in the Medical Protocol and Periodicity Schedule. For each recipient aged ten years through 20 years, an agency may claim only one health assessment per year. Additional visits for high-risk recipients are not considered to be PGH health assessments but are reimbursable according to the fee schedules in Sections 421.601 and 421.602.

(C) Report Requirement. In order to claim payment for a PGH health assessment, an agency must submit a completed PGH/EPSDT Claim Form and Medical Examination Report (MA-8P). The MA-8P is a form specifically designed to collect written documentation of the screening procedures provided and each result, including problems needing follow-up treatment, as required by federal EPSDT regulations. Instructions for obtaining and completing the MA-8P are located in Subchapter 5 of the Family Planning Agency Manual.

(1) When submitting a claim for a health assessment with special circumstances, the agency must attach its statement (see Subsection 421.446(B)) to the MA-8P form. (See the billing instructions in Subchapter 5 of the Family Planning Agency Manual.)

(2) If a nurse practitioner or physician assistant has performed the health assessment, this must be indicated in

the appropriate space on the MA-8P form (see the billing instructions in Subchapter 5 of the Family Planning Agency Manual).

(D) Fee Schedule.

Service Code	Service Description	Allowable Fee
	Comprehensive Family Planning Agencies	
160041	Comprehensive visit/PGH health assessment: complete initial, annual, or extended visit and complete PGH health assessment (MA-8P form required)	$ 40.50
160043	Comprehensive visit/PGH health assessment with special circumstances: complete initial, annual, or extended visit and PGH health assessment with special circumstances (MA-8P form required) (medical review)	40.50
	Medical and Counseling Family Planning Agencies	
160042	Comprehensive visit/PGH health assessment: complete initial, annual, or extended visit and complete PGH health assessment (MA-8P form required)	36.50
160044	Comprehensive visit/PGH health assessment with special circumstances: complete initial, annual, or extended visit and PGH health assessment with special circumstances (MA-8P form required) (medical review)	36.50

421.450: Project Good Health Services: Claims for Laboratory Services

The following laboratory services, which are included in the Medical Protocol and Periodicity Schedule, are reimbursable in addition to the health assessment when performed in the agency that furnished the health assessment. The fees for these laboratory services are located in Section 421.604. An agency may not claim payment for any test until the results are known.

Service Code	Service Description
108112	Cholesterol, total
108665	Culture, GC (gonococcus culture)
108885	Culture, routine, any source
108379	Erythrocyte protoporphyrin
108368	Hematocrit (HCT)
108366	Hemoglobin (HGB), colorimetric
108260	Lead screening, blood
108920	Pap (Papanicolaou) smear; cytopathology smear; Gravlee jet washing
108653	Serology; rapid plasma reagin (RPR)
108442	Sickle cell preparation
108340	Triglycerides, blood
108708	Urinalysis, complete (includes dip stick and microscopic exam and specific gravity)
108873	Urinary dip stick (pH, blood, ketones, glucose, nitrites) per combination dip stick

421.451: Project Good Health Services: Claims for Audiometric Hearing Test

Payment for the audiometric hearing test, which is included in the Medical Protocol and Periodicity Schedule, is not included in the fee for a health assessment and should be claimed separately according to the fee schedule below.

Service Code	Service Description	Allowable Fee
169350	Audiometric hearing test, pure-tone, air only	$ 5.50

421.452: Project Good Health Services: Recordkeeping Requirements

(A) Medical Records. A family planning agency must create and maintain a centralized record for every PGH recipient in its care, in accordance with Department regulations governing medical records generally (see Section 421.423). In addition, the record for each PGH recipient must contain documentation of the screening procedures listed in Subsections 421.445(A) through (P) as well as the following:

(1) the results of all laboratory tests;
(2) the name and address of each referral provider; and
(3) the date and results of each referral appointment, if the appointment was kept.

(B) Determination of Compliance with Medical Standards. The Department may review an agency's medical records of PGH recipients to determine the necessity, propriety, and quality of the medical care furnished. These determinations will be made by medical professionals in accordance with 106 CMR 450.206. The Department may request review by the Massachusetts Chapter of the American Academy of Pediatrics, or other appropriate professional organization, for the purposes of making such determinations. This review will be considered before the Department proceeds with administrative action based on a determination of noncompliance with medical standards as defined in 106 CMR 450.204.

(106 CMR 421.453 through 421.600 Reserved)

421.601: Fee Schedule: Visits to a Comprehensive Family Planning Agency

Service Code	Service Description	Allowable Fee
160000	Comprehensive visit: complete initial, annual, or extended visit	$ 35.00
160001	Routine visit: follow-up medical visit	20.00
160002	Minimal service visit: brief medical or counseling service for minor problem (this visit is not to be used for resupply only)	15.00

421.602: Fee Schedule: Visits to a Medical and Counseling Family Planning Agency

Service Code	Service Description	Allowable Fee
160030	Comprehensive visit: complete initial, annual, or extended visit	$ 31.00
160031	Routine visit: follow-up medical visit	16.00
160032	Minimal service visit: brief medical or counseling service for minor problem (this visit is not to be used for resupply only)	11.00

421.603: Fee Schedule: Contraceptive Supplies and Drugs

Service Code	Service Description	Allowable Fee
160003	Birth control pills	$ .46
160022	Lippes Loop IUD	11.67
160004	Saf-T-Coil IUD (without sound)	5.25
160012	Cu-7 IUD	20.77
160013	Progestasert-T (report required)	13.50
160005	Diaphragm (including applicator and contraceptive cream or jelly)	5.73
160007	Condoms (three)	.47
160014	Contraceptive jelly (81 gram with applicator)	3.36
160015	Contraceptive jelly (135 gram refill)	3.36
160016	Contraceptive cream (75 gram with applicator)	3.36
160017	Contraceptive cream (128 gram refill)	3.36
160018	Contraceptive foam (22 gram with applicator)	3.10
160019	Contraceptive foam (55 gram refill)	3.81
160021	Contraceptive suppositories (packet of 10)	3.05
160020	Contraceptive suppositories (packet of 12)	3.14
160009	Medications and injectables related to family planning services, with the exception of Rho (D) human immune globulin (the Department will pay for the above items at the agency's cost)	I.C.

421.604: Fee Schedule: Laboratory Services

(A) Individual Tests. The following fee schedule lists the maximum allowable fees for individual tests.

Service Code	Service Description	Allowable Fee
108215	Beta sub unit	$ 10.00
108087	Bilirubin, total and fraction	5.00
108363	Blood count (RBC)	2.00
108364	Blood count (WBC)	2.00
108365	Blood count, differential	4.00
108951	Cell count, miscellaneous body fluids, except blood (e.g., CSF, joint, etc.)	2.00
108817	Centrifuging and mailing specimen	1.00
108113	Cholesterol, ester	5.00
108112	Cholesterol, total	5.00
108927	Chromosome analysis (karyotype)	5.00
108361	Complete blood count (CBC) (includes WBC, RBC, hemoglobin, hematocrit, and differential indices)	7.00
108122	Creatine, blood	5.00
108747	Creatine, urine	5.00
108123	Creatine phosphokinase (CPK)	8.00
108125	Creatinine, chemistry	5.00
108126	Creatinine clearance	10.00
108748	Creatinine, urine	5.00
108665	Culture, GC (gonococcus culture)	7.00
108885	Culture, routine, any source	5.00

Service Code	Service Description	Allowable Fee
108897	Culture and sensitivity, antibiotic	$ 8.00
108898	Culture, sensitivity, and colony count	7.50
108888	Culture, urine (quantitative) with colony count	8.00
108379	Erythrocyte protoporphyrin	5.00*
108214	Estriol, blood	20.00
108783	Estrogens, urine, fractionated into estrone, estradiol, and estriol	30.00
108782	Estrogens, urine total, nonpregnant state	20.00
108138	Folic acid, vitamin M (folate level)	10.00
108795	Follicle stimulating hormone (FSH) by RIA; urinary pituitary gonadotropins	17.50
108665	GC culture (gonococcus culture)	7.00
108642	Glucose, spinal fluid	5.00
108320	Glucose; sugar; postprandial sugar; fasting blood sugar (FBS)	5.00
108864	Glucose; sugar, quantitative, 24-hour specimen	4.00
108322	Glucose tolerance (maximum of $20.00)	4.00/assay
108176	Glucose 6-phosphate-dehydrogenase (G-6-PD) quantitative	6.00

*Send to: State Lead Poison Prevention Program
305 South Street
Jamaica Plain, MA 02130

Service Code	Service Description	Allowable Fee
108175	Glucose 6-phosphate-dehydrogenase (G-6-PD) screen	$ 5.00
108794	Growth hormone, GH or HGH, by RIA	10.00
108368	Hematocrit (HCT)	2.00
108366	Hemoglobin (HGB), colorimetric	2.00
108978	Herpes simplex titer	10.00
108510	Heterophile: antibodies, screening (includes mono-type test)	5.00
108513	Heterophile exclusion	9.00
108787	Hydroxycorticosteroids, reduced ketogenic Porter-Silber	10.00
108224	Iodine, protein bound (PBI)	6.00
108242	Iron	5.00
108246	Iron binding capacity, Irosorb (TIBC) (includes iron)	5.00
108790	17-Ketosteroids, total	10.00
108255	Lactic dehydrogenase (LDH)	5.00
108260	Lead screening, blood	1.00*
108219	Luteinizing hormone, blood (LH)	10.00
108282	Mono test (rapid screening)	5.00
108600	Occult blood	3.00
108705	Occult blood, urine	3.00

*Send to: State Lead Poison Prevention Program
305 South Street
Jamaica Plain, MA 02130

Service Code	Service Description	Allowable Fee
108920	Pap (Papanicolaou) smear; cytopathology smear; Gravlee jet washing	$ 6.00
108293	Phosphatase acid	5.00
108295	Phosphatase alkaline, blood	5.00
108296	Phosphatase alkaline, fractionated (isoenzymes) (electrophoresis)	15.00
108795	Pituitary gonadotropins, urinary (FSH), by RIA	17.50
108301	Potassium (K), blood	5.00
108853	Potassium (K), urine	5.00
108202	Pregnancy test, tube (U.C.G.)	5.00
108209	Pregnancy test, slide	5.00
108217	Progesterone, blood	10.00
108305	Protein, electrophoresis	15.00
108645	Protein, quantitative, spinal fluid	4.00
108303	Protein, total	4.00
108434	Prothrombin time (activity) (PT)	5.00
108440	Reticulocyte count	4.00
108464	Rh titer, A, B and others, albumin or saline technic, each	5.00
108480	Rh typing	3.00
108483	RhoGam type (anti Rh immunoglobulin testing)	5.00
108530	Rubella, C-F test, single test	6.00
108528	Rubella, H.I., acute and convalescent (two tests, same recipient)	10.00

Service Code	Service Description	Allowable Fee
108527	Rubella, H.I., single sample	$ 5.50
108441	Sedimentation rate; erythrocyte sedimentation rate (ESR); Wintrobe	5.00
108975	Semen analysis, complete (volume count, motility, differential)	8.00
108973	Semen analysis (including Huhner)	15.00
108897	Sensitivity and culture, antibiotic	8.00
108653	Serology; rapid plasma reagin (RPR)	5.00
108442	Sickle cell preparation	6.00
108882	Smear, acid fast (AF), sputum, concentrated specimen	6.00
108654	Smear for bacteria (spinal fluid)	3.00
108924	Smear, buccal for chromosomal sex determination (Barr)	6.00
108367	Smear, buffy coat	3.00
108922	Smear, cytopathology, other than genital	8.00
108880	Smear, routine (initial microscopic examination)	3.00
108862	Sodium (Na)	5.00
108534	S.T.S. flocculation (standard test for syphilis)	5.00
108937	Surgical pathology, multiple specimens and/or extensive dissection with individual identification or unusual preparation	15.00
108936	Surgical specimen, gross	7.50

Service Code	Service Description	Allowable Fee
108934	Surgical specimen, gross and microscopic exam, per specimen	$ 15.00
108227	T-3 total (tri-iodo-thyronine)	10.00
108331	T-4 (thyroxine)	10.00
108223	Testosterone, blood	25.00
108234	Thyroid stimulating hormone (TSH)	10.00
108335	Transaminase SGOT	5.00
108337	Transaminase SGPT	5.00
108340	Triglycerides, blood	10.00
108999	Unlisted test	I.C.
108708	Urinalysis, complete (includes dip stick and microscopic exam and specific gravity)	4.00
108873	Urinary dip stick (pH, blood, ketones, glucose, nitrites) per combination dip stick	1.00
108666	VDRL	5.00
108881	Wet mount, any source, potassium hydroxide	3.00

(B) Profile Tests.

(1) "List A" Profiles. When one or two of the tests listed here are performed as individual (bench) tests, the family planning agency may bill according to the fee for the individual test (see Subsection 421.604(A)). However, when three or more of these tests are performed as a profile (as defined in Subsection 421.433(C)), the agency must bill according to the rates below. If one or more tests in the profile are not in the list below, but are in the fee schedule of individual tests (see Subsection 421.604(A)), the maximum allowable fee is the sum of the maximum allowable fee for the profile plus the maximum allowable fees for the individual tests listed in Subsection 421.604(A).

List A

(Note: The following profiles are frequently composed of tests in List A and should be billed for accordingly: cardiac profile, cerebral spinal fluid profile, hypertension screen, lipid profile, liver function profile, and renal profile.)

Albumin	Iron
Alkaline phosphatase	LDH
Bilirubin, total and direct	Phosphorus
BUN (urea nitrogen)	Potassium
Calcium	SGOT
Chloride	SGPT
Cholesterol	Sodium
CO_2	Total protein
Creatinine	Triglycerides
Globulin	Uric acid
Glucose	

Service Code	Service Description	Allowable Fee
108004	3 through 7 tests	$ 8.00
108008	8 through 12 tests	10.00
108013	13 through 17 tests	15.00
108018	18 tests and over	20.00

8062 012

(2) Other Profiles. These profiles must be billed as a group, whether they are performed manually or automatedly (see Subsection 421.433(C)).

Service Code	Service Description	Allowable Fee
108027	Prenatal Blood group and Rh factor CBC Rubella antibody RPR Antibody screen	$ 15.00
108048	Thyroid T_3-uptake T_4 Free thyroxine index	12.00

REGULATORY AUTHORITY

106 CMR 421.000: M.G.L. c. 18, s. 10; M.G.L. c. 118E, s. 4.

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